No. 80-419

Office Supreme Court, U.S.
JUN 10 1981

IN THE
Supreme Court of the United States
OCTOBER TERM, 1980

STATE OF ARIZONA,
Petitioner,

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
Pima Foundation For Medical Care,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

Vol. 2 Pages 275-541

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PETITION FOR CERTIORARI FILED SEPTEMBER 16, 1980
CERTIORARI GRANTED MARCH 9, 1981

EXHIBIT J

EXHBT. 31 FOR I D
HOLIDAY & ASSOCIATES
KENNETH R. MILLER
DATE 11-22-78
(Mitten Depo)

MARICOPA FOUNDATION FOR MEDICAL CARE

September 30, 1977

TO: All Foundation Doctors

Dear Doctor:

Enclosed is a ballot which asks your opinion of a proposed increase in the conversion factors used by the Foundation. If these increases are approved by a simple majority, they will become effective December 1, 1977 for all insurance plans initiated or renewed after that date.

Since its inception in 1969, the Foundation has attempted to convince the public that private practice, fee-for-service medicine is not only superior in regard to patient care, but is also cost effective. Because we have all been faced with increased expenses we are necessarily forced to consider a change in the fee schedules we use. We urge you to voice your feelings by responding with this ballot.

In the near future you will be receiving an application for participation in the Foundation in the calendar year 1978. We hope you will continue to support the Foundation concepts and activities. The Board of Trustees sincerely appreciate comments concerning any aspect of the Foundation operation.

Sincerely,

Lawrence J. Shapiro, M.D.
PRESIDENT

LJS:lm

Enclosure

MARICOPA FOUNDATION FEE SCHEDULE BALLOT

Based on the California Medical Association's Relative Value Study of 1964, the conversion factors should be as follows:

$10.50 per unit for surgery
$12.25 per unit for medicine and pathology
$ 7.50 per unit for clinical laboratory
$13.25 per unit for anesthesiology (based on the 1973 ASA Guide)
$ 8.50 per unit for radiology (based on the ACR, 1973)

( ) YES ( ) NO

If you decide to vote no we would appreciate your comments:

Name (please print)

EXHIBIT K

EXHBT. 34 FOR I D
HOLIDAY & ASSOCIATES
KENNETH R. MILLER
DATE 11-22-78
(Mitten Depo)

MINUTES

MARICOPA FOUNDATION FOR MEDICAL CARE

BOARD OF TRUSTEES

October 17, 1977

PRESENT: Doctors: Norman Brown, M.D., James Campbell, M.D., Richard Daley, M.D., Robert Diserens, M.D., Keith Harris, M.D., Rudger Hiatt, M.D., James Laugharn, M.D., Donald Miles, M.D., Patrick P. Moraca, M.D., William Myers, M.D., Lawrence J. Shapiro, M.D., and Ronald Suiter, M.D.

Guests: Doctors Herbert Brown, M.D., Ira B. Ehrlich, M.D., Neil Ward, M.D., Mr. Anthony D. Mitten and Mrs. Dwyn Keller.

MINUTES: The minutes of the September 19, 1977 Board of Trustees meeting were reviewed and accepted as submitted.

FINANCIAL REPORT: The financial report for September was discussed at length and approved as submitted.

FEE SCHEDULE BALLOT: The ballot report indicated a majority of the ballots returned with 691 members approving the following conversion factors. $10.50 per unit for surgery, $12.25 per unit for medicine and pathology, $7.50 per unit for clinical laboratory, $13.25 per unit for anesthesiology (based on the 1973 ASA Guide), $8.50 per unit for radiology (based on the ACR, 1973).

A letter from Don Schaller, M.D. was read. The content of this letter was felt to be erroneous in nature since the increase is only 5% over a two year period of time.

AAFMC DUES: The billing for the annual American Association of Foundations for Medical Care dues in the amount of $680.00 was approved for payment.

ARIZONA PIPE TRADES UNION: The proposal submitted by Martin Segal Company for Foundation sponorship, CHAP and Peer Review was discussed. It was the consensus of the Board to investigate the conversion factors used for payment to non-member physicians and to obtain a more concrete proposal showing a comparison of the conversion factors for the next Board meeting.

PSRO: George Stavros, M.D. has been nominated to serve as Executive Medical Director for the Northern Arizona Medical Evaluation Systems PSRO during the planning period of the PSRO grant. He will submit a schedule outlining the duties to be undertaken in the performance of this job.

EXHIBIT L

PIMA FOUNDATION FOR MEDICAL CARE

MAXIMUM FEE SCHEDULE FOR PREVENTATIVE CHILD CARE

Newborn Care (routine)	$35.00
Well infant or Well child office visits	12.00
DPT	5.00
Tri Sabin Oral Polio	5.00
PPD skin test	5.00
Cocci skin test	5.00
Hemoglobin or Hematocrit	2.50
Urinalysis	4.50
Measles, Mumps or Rubella (separately)	10.00
Combination of two where available (Mumps-Rubella or Measles-Rubella)	15.00
MMR (Measles-Mumps-Rubella)	20.00

EXHIBIT M

MINUTES

MARICOPA FOUNDATION FOR MEDICAL CARE

FEE REIMBURSEMENT COMMITTEE

May 22, 1978

PRESENT: Doctors: Richard Daley, M.D., John Kelley, M.D., Richard Pendergast, Robert Fox, M.D., Norman Brown, M.D., Keith Harris, M.D., Lawrence Shapiro, M.D., Laurance Nilsen, M.D. and William Devine, D.O.

Staff: Anthony D. Mitten and Dwyn Keller

The goals of this committee were discussed and several methods were considered to accomplish the Board directive to upgrade the present method of identifying services to the Foundation for payment.

This committee approved using the 1974 RVS complete with unit values. Each specialty is to establish a conversion factor to use with 1974 RVS that will reflect the current Foundation payment. This recommendation will be brought to the June 19, 1978 Foundation Board meeting.

Doctor Harris requested each member to also list the procedures that were gross inequities and bring these to the next meeting of this committee for consideration prior to requesting Board approval of any charges.

This committee will meet again on June 26, 1978 to discuss acceptable conversion factors.

There being no further business, the meeting was adjourned at 8:00 p.m.

Respectfully sumitted,

Keith Harris, M.D.
Chairman

EXHIBIT N

BY-LAWS
OF
PIMA FOUNDATION FOR MEDICAL CARE

CHAPTER I
GENERAL PROVISIONS AND PROPERTY INTERESTS

Section 1. Business to be conducted without profit: This corporation shall conduct and carry on its business without profit to itself or its members, or any class thereof. No member of this corporation shall, by reason of membership herein, be or become entitled at any time to receive any assets, property, income, or earnings from the corporation, or to profit therefrom in any manner.

Section 2. Use of income: All of the income, revenue, and earnings of the corporation shall be held, used, managed, devoted, expended and applied in the discretion and judgment of the Trustees, to carry out the objects and purposes of the corporation, and without profit, direct or indirect, to any member of the corporation as such.

Section 3. Distribution of assets on dissolution: In the event of the dissolution of this corporation, all of its assets and property, after payment and satisfaction of all claims and demands against the corporation and all liabilities of the corporation, shall be conveyed and transferred to such non-profit, charitable organization as the Board of Trustees of this corporation shall determine.

CHAPTER II
MEMBERSHIP

Section 1. Classes of membership: There shall be only one class of membership in this corporation. It shall be known as Corporate Members. Any physician who has previously

applied for and been accepted as a Participating or a Cooperating Member shall hereafter be a Corporate Member until his membership shall be terminated as provided in these By-Laws.

Section 2. Qualifications of Corporate Members: Any physician or podiatrist authorized by the statutes of the State of Arizona to practice medicine in the State of Arizona, who practices in Pima County or a county contiguous to Pima County shall be eligible to apply for membership as a Corporate Member. This membership may be granted by the Board of Trustees to any such person so qualified upon making application therefor. The dues and assessments to be charged for admission to Corporate Membership, or to be imposed upon members shall be determined by the Board of Trustees.

Section 3. Rights and privileges of Corporate Members: Corporate Members shall have the right to vote on the adoption of any contract limits for medical services by the Foundation. Adoption of any such schedule for medical services shall be by mail ballot. A simple affirmative majority of those ballots received shall be required for adoption. On any such issue submitted to the Corporate Members, the voting power of Corporate Members shall be equal to that of every other entitled to one vote on issues submitted to the Corporate Members. Both cumulative and proxy voting are expressly prohibited. Adoption of any contract limits by the membership notwithstanding. The Board of Trustees may negotiate health care contracts on behalf of the Foundation and such contracts will be binding on the Foundation, even though they may represent a variance or potential variance from the established contract limits. In such cases, however, the membership must be polled regarding the acceptability of the contract limits within a reasonable time, and in no event to exceed one year from

the date of such contracts. Voting shall be by mail ballot and the results of the voting will be a determining factor to be considered by the Trustees in re-negotiating the contracts in question.

Section 4. Term of membership: Corporate Membership shall be for a five (5) year period of time. Membership may be determined by (A) Voluntary request in writing by the Corporate Member to resign his membership submitted to the Board of Trustees to become effective January 1, of the following year; or (B) involuntary termination as initiated and undertaken according to Chapter XII, Section 8, of these By-Laws.

Section 5. Procedure for admission to Corporate Membership: Any person who desires to become a Corporate Member of this corporation shall fill out and sign in duplicate the application blank provided for that purpose by the corporation. Such application blank shall be in the form or forms determined by the Board of Trustees, and shall contain a clause stating in substance that the applicant agrees to be bound by the constitution, By-Laws, and rules and regulations of this corporation; that said applicant agrees to be bound by the principles of professional conduct of this corporation; that the applicant, as long as his membership in this corporation is effective, agrees to be bound by any and all rules, regulations, committee decisions, contract limits, and the like, adopted by this corporation.

Said application shall be filed with the secretary-treasurer at the principal office of the corporation. The application shall be referred by the secretary-treasurer to the Membership Committee, which shall investigate the background and present status of the applicant, and shall report to the Board of Trustees, with a recommendation, thereon. At the next meeting of the Board of Trustees, the president shall announce the names of those applicants submitted to it by the Membership Committee, and the committee recommen-

dation, if any. Each applicant shall thereupon be voted on individually; and it shall require a two-thirds majority vote of the Board of Trustees to elect to membership.

Section 6. Non-transferability of membership: Neither Corporate Membership in this corporation nor any certificate evidencing the same nor the interest of any Corporate Member in this corporation, or any of the assets thereof, shall (A) be subject to execution or become or be an asset of the estate of any deceased member, or of any member who may become insolvent or bankrupt, (B) descend to or vest in the heirs, legatees, or devisees or any member, or (C) be transferable or assignable in any form either by the voluntary or by the involuntary act of any member, or by operation of law. In the event of the death, insolvency or bankruptcy of any member of this corporation or of any certificate evidencing the same or of any interest of any member in this corporation, or any of the assets thereof, whether by the voluntary act of the member or otherwise, such membership certificates and all interests of any such member in this corporation and all assets thereof shall be immediately cancelled, revoked and terminated.

Section 7. Membership roll: A written record of the Corporate Membership of this corporation shall be kept by the secretary and said record shall contain the name and address of each Corporate Member, and in any case where any membership has been terminated for any reason whatsoever, an entry of such fact, together with the date upon which said membership was so terminated.

CHAPTER III
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates: Certificates of membership shall be of such form and device as the Board of Trustees may prescribe. Each certificate shall express on its face the year issued, and person to whom it is issued. Certificates of membership shall be non-transferable. Issuance to and acceptance by a member of such certificate of membership shall be conclusive evidence of the consent of the member

to become a Corporate Member of this corporation, and of this agreement to comply with and be governed by all the provisions of the articles of incorporation, By-Laws and rules and regulations of this corporation. Certificates of membership in this corporation shall be cancelled by the secretary whenever a member ceases to be eligible as such, or whenever the membership of the member terminates, in accordance with the provisions of the articles of incorporation, or these By-Laws. All certificates of membership shall be signed by the president or vice-president and by the secretary of this corporation.

CHAPTER IV
MEETING OF MEMBERS

Section 1. Annual meetings; Annual meetings of all members shall be held on the second Tuesday of December in a location to be designated by the Board of Trustees. Notice of all annual meetings of members will be given to all members.

Section 2. Regular meetings: Regular meetings of the Board of Trustees shall be held monthly at the corporate offices of the organization.

Section 3. Special meetings: Special meetings of Corporate Members, for any purpose or purposes whatsoever, may be called at any time by the president or the Board of Trustees; or by one-third of the members. Notice of special meetings shall be given to each member entitled to vote thereat either personally or by mail addressed to such member at his address appearing upon the books of the corporation at least ten (10) days in advance of the date of such special meetings; and such written notice shall also state the place, day and hour of such meeting and general nature of the business to be transacted. No business shall be transacted at a special meeting other than stated in the purposes set forth in the notice. Special meetings may be held at the principal office of the corporation or at any other place within Pima County, State of Arizona.

Section 4. Adjourned meetings and notice thereof: Any members' meeting, annual or special, whether or not a quorum is present, may be adjourned from time to time by the vote of a majority of the members who are present in person; but in the absence of a quorum, no other business may be transacted at any such meeting. A quorum shall consist of twenty-percent (20%) of the Corporate Membership of the corporation.

When any members' meeting, either regular, annual or special, is adjourned for thirty (30) days or more, notice of the adjourned meeting shall be given as in the case of an original meeting. Save as aforesaid, it shall not be necessary to give notice of any adjournment or of the business to be transacted at any adjourned meeting, other than by an announcement at the meeting at which such adjournment is taken.

Section 5. Entry of notice: Whenever any member entitled to vote has been absent from any special meeting of members, or a class thereof, an entry in the minutes to the effect that notice has been duly given shall be conclusive and incontrovertible evidence that due notice of such meeting was given to such member or members as required by law and the By-Laws of this corporation.

Section 6. Consent of absentees: The transaction of any meeting of members, or a class thereof, either regular, annual, or special, however called and noticed, shall be as valid as though had a meeting duly been held after regular call and notice if a quorum be present in person, sign a written waiver of notice or consent to the holding of such meeting or an approval of the minutes thereof. All such waivers, consents, or approvals shall be filed with the corporate records or made a part of the minutes of the meeting.

Section 7. Action without meeting: Any action which may be taken at a meeting of the members, or a class thereof, may be taken without a meeting if authorized by a writing signed by all of the members who would be entitled to vote at a meeting of such purpose, and filed with the secretary of the corporation.

CHAPTER V
CORPORATE POWERS

Section 1. Corporate powers vested in Board of Trustees: The corporate powers of this corporation shall be vested in a Board of at least twelve (12) Trustees. Two-thirds of said Trustees shall constitute a quorum for the transaction of business.

Section 2. Powers of Trustees: Subject to these By-Laws, the Board of Trustees shall have full and sole power to control and manage the property and conduct the affairs and business of this corporation; and in furtherance of the foregoing powers, but not in limitation thereof, it shall have power:

First: To select and remove all the other officers, agents and employees of the corporation, prescribe such powers and duties for them as may not be inconsistent with law, with the articles of incorporation, or with these By-Laws; fix their compensation; and require from them security for faithful service.

Second: To conduct, manage and control the affairs and business of the corporation; and to make such rules and regulations therefore not inconsistent with law, with the articles of incorporation, or with these By-Laws, as they may deem best.

Third: To procure the membership application forms and membership certificate forms; and to alter such membership application forms and membership certificates from time to time.

Fourth: To make assessments, borrow money and incur indebtedness for the purpose of the corporation; and to cause to be executed and delivered therefor in the corporation name promissory notes, bonds, deben-

tures, deeds of trust, mortgages, pledges, hypothecations, or other evidences of debt and securities therefor subject only to concurrence of two-thirds of the Board of Trustees.

Fifth: To appoint an executive committee and other committees, and to delegate to the executive committee any of the power and authority of the Trustees in the management of the business and affairs of the corporation, except the power to adopt, amend, or repeal By-Laws. The executive committee shall be composed of three or more Trustees of this corporation and membership therein is expressly limited to Trustees.

Sixth: to appoint and employ an executive secretary or manager, and any subordinate officials and employees.

Seventh: To consider, approve or disapprove all recommendations of any committee; and to adopt and to propose to the Corporate Members contract limits for medical services, which when adopted by a majority vote of the Corporate Membership shall be binding upon all Corporate Members of this Corporation while, and so long as they are Corporate Members in good standing of this corporation.

CHAPTER VI
BOARD OF TRUSTEES

Section 1. Terms of office: The first Trustees designated as such in the articles of this corporation shall hold office and exercise all powers granted to the Board of Trustees until the next regular annual meeting of the Corporate Members of this corporation. Thereafter, a new Board of Trustees shall be elected by the Corporate Members in accordance with these By-Laws. The new Board of Trustees so elected may be composed of all, some, or none of the first Trustees designated as such in the articles of incorporation. Four (4) members of said Board of Trustees shall be elected for a period of three (3) years; four (4) for a period of two (2) years; and four (4) for a period of one (1) year. Yearly

thereafter, four (4) new members shall be elected to the Board of Trustees of this corporation for a period of three (3) years. No more than three (3) consecutive terms may be served by any one individual.

Section 2. Removal from office: Any Trustee may be removed from office as such by the affirmative vote of two-thirds of the members, at any annual or special meeting of the members, on written notice satting forth the reasons and ground therefor, mailed to such Trustee at his last known address at least ten (10) days prior to the date of such meeting. Three (3) consecutive unexcused or four (4) unexcused absences in any twelve (12) months shall be sufficient grounds for summary dismissal from the Board of Trustees.

Section 3. Vacancies: In the event of a vacancy on the Board of Trustees, the vancancy shall be filled by a majority vote of the Board of Trustees for the remainder of the vacancy term.

Section 4. Amendment for expansion of Board: The Board of Trustees of this corporation shall be composed of at least twelve (12) persons, two-thirds (⅔) of whom must be Corporate Members of this corporation. One-third (⅓) may be lay (non-physician) individuals from the Pima County, Arizona community selected for their interest in the provisions of quality health services to the community compatible with the philosophy, objectives and ethics of the Pima Foundation for Medical care. Initially one-third (⅓) of lay-members will be elected for three (3) years, one-third (⅓) for two (2) years and one-third (⅓) for one (1) year, and yearly thereafter each lay-member will be lected for three (3) year periods.

CHAPTER VII
MEETINGS

Section 1. Regular meetings: Regular meetings of the Board of Trustees shall be held. The scheduled time and location of such meetings shall be at the office of the Pima Foundation for Medical Care.

Section 2. Special meetings: Special meetings of the Board of Trustees for any purposes shall be called at any time by the president, or any three (3) Trustees. Written notice of the time and place of special meetings shall be delivered or sent to each Trustee at his address as it is shown upon the books of the corporation. In such case notice is mailed, it shall be deposited in the United States mail at least seventy-two (72) hours before the time of the holding of the meeting. Mailing or delivering shall be due, legal and personal notice of such Trustees.

Section 3. Written consents and waiver of notice: The transactions of any meetings of the Board of Trustees, however called and noticed, or wherever held, shall be as valid as though had a meeting duly been held after regular call and notice. If a quorum be present, and if, either before or after the meeting, each of the Trustees not present sign a written waiver of notice or consent to holding such meeting or an approval of the minutes thereof. All such waivers, consents, or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

CHAPTER VIII
OFFICERS

Section 1. Officers: The officers of this corporation shall be a president, a vice-president, a secretary, a treasurer, and such other officers as the Board of Trustees may appoint.

Section 2. Election: The officers of the corporation shall be chosen annually by the Board of Trustees from its membership at its organization meeting, and each shall hold his office until he shall resign or shall be removed or otherwise disqualified to serve, or his successor shall be elected and qualified.

Section 3. Removal and resignation: Any officer may be removed, either with or without cause, by a majority of the Trustees in office at the time, at any regular or special meeting of the Board. Any officer may resign at any time by giving written notice to the Board of Trustees or to the president or to the secretary of the corporation. Any such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein; and unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

Section 4. Vacancies: A vacancy in any office because of death, resignation, removal, disqualification, or any other cause shall be filled by the Board of Trustees until the next annual election of officers.

CHAPTER IX
DUTIES OF OFFICERS

Section 1. President: The president shall be the chief executive officer of the corporation, and shall, subject to the control of the Trustees, have general supervision, direction, and control of the business and officers of the corporation. He shall preside at all meetings of the members and at all meetings of the Trustees. He shall be at all meetings of the members and at all meetings of the Trustees. He shall be ex-officio a member of all the standing committees including the executive committee, if any, and shall have the general powers and duties of management usually vested in the office of the president of a corporation, and shall have such other powers and duties as may be prescribed by the Board of Trustees or these By-Laws.

Section 2. Vice-President: In the absence or disability of the president, the vice-presidents in order of their rank as fixed by the Board of Trustees—or, if not ranked, the vice-president designated by the Board of Trustees—shall perform all the duties of the president, and when so acting, shall have all the powers of, and be subject to, all the restrictions upon the president. The vice-president shall have such other powers and perform such other duties as from time to time may be prescribed for them respectively by the Trustees or by these By-Laws.

Section 3. Secretary: The secretary shall keep, or cause to be kept, a book of minutes at the principal office of the corporation, or such other place as the Board of Trustees may order, of all meetings of the Board of Trustees and Corporate Members, with the time and place of holding, whether special or regular, and if special, how authorized, the notice thereon given, the names of those present at Board meetings, the number of members present at members' meetings, and the proceedings thereof. He shall also keep and maintain the membership certificate book and membership roll of the membership of this corporation, and records of all terminations of memberships in this corporation.

The Secretary shall give, or cause to be given, notice of all the meetings of members and of the Trustees required by these By-Laws or by the law to be given and he shall have such other powers and perform such other duties as may be prescribed by the Board of Trustees or by these By-Laws.

Section 4. Treasurer: The treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of the corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses.

The treasurer shall deposit all monies and other valuables in the name and to the credit of the corporation with such depositaries as may be designated by the Board of Trustees. He shall disburse the funds of the corporation as may be

ordered by the Board of Trustees; shall render to the president and the Board of Trustees, whenever they request it, an account of all his transactions as treasurer, and of the financial condition of the corporation; and shall have such other powers and perform such other duties as may be prescribed by the Board of Trustees or by these By-Laws.

CHAPTER X
EXECUTIVE COMMITTEE AND OTHER COMMITTEES ESTABLISHED BY TRUSTEES

Section 1. Executive Committee: There is hereby created an executive committee to consist of the president, the vice-president, the secretary, and the treasurer of the corporation. Such executive committee shall be vested with all of the powers of the Board of Trustees when the Board of Trustees is not in session.

Section 2. Standing committees: Standing committees of this corporation shall be as follows:

A. Constitution and By-Laws Committee

B. Membership Committee

C. Actuarial Advisory Committee

D. Minimum Standards Committee

E. Peer Review Committee

Section 3. Qualifications and terms of office of committee members: The members of the committees shall be appointed by the president, subject to the approval of the Board of Trustees, and shall hold office for a period of one year.

Section 4. Composition and duties of committees: Each standing committee shall have as many members thereon as the Board of Trustees may from time to time determine, and shall have such duties and perform such functions as may be required of them by the Board of Trustees from time to time.

Section 5. Other committees: The Board of Trustees may from time to time create other standing and special committees, appoint the numbers thereof, and invest therein such powers and duties as it may deem desirable.

CHAPTER XI
ELECTIONS

Section 1. Board of Trustees: The Corporate Members of this corporation shall elect, by a majority vote, and in accordance with these By-Laws and the articles of incorporation, the Board of Trustees of this corporation. The Nominating Committee shall present to the membership forty-five (45) days prior to date of election at least one nominee for each vacancy on the Board of Trustees. Each nominee must have agreed to accept the nomination. These nominations will be mailed to the membership at least thirty (30) days prior to election. Nominations may be made by the membership. The nomination must be made by five Corporate Members and the nominee must have agreed to accept the nomination. Election will be made by mail ballot sent fourteen (14) days prior to the date of election, and the counting of ballots which will coincide with the date of the annual meeting.

Section 2. Officers: The Board of Trustees of this corporation, at the next regular meeting following their election to said Board, shall by simple majority vote, and in accordance with these By-Laws, elect the officers of this corporation.

CHAPTER XII
MISCELLANEOUS

Section 1. Inspection of corporate records: The membership roll or register or duplicate membership roll or register, the books of accounts, and the minutes of proceedings of members and Trustees shall be open to inspection upon written demand of any Corporate Member at any reasonable time, and for a purpose reasonable related to his interest as such member and shall be exhibited at any time when required by the demand of ten (10) percent of the members. De-

mand of inspection other than that at a members' meeting shall be made in writing upon the president, or the secretary.

Section 2. Checks, drafts, etc: All checks, drafts, or other order for payment of money, notes, or other evidences of indebtedness issued in the name or payable to the corporation shall be signed or endorsed by such person or persons, and in such manner, as from time to time shall be determined by resolution of the Board of Trustees.

Section 3. Annual Report: The Board of Trustees shall cause to be sent to the members, not later than one hundred twenty (120) days after the close of the fiscal or calendar year, an annual report of the financial affairs of the corporation.

Section 4. Contracts, etc. - how executed: The Board of Trustees, except as in these By-Laws otherwise provided, may authorize any officer or officers, agent or agents to enter into any contract or to execute any instrument in the name of any on behalf of the corporation, and such authority may be general or confined to specific instances. Unless so authorized by the Board of Trustees, no officer, agent, or employee shall have any power or authority to bind the corporation by any contract or engagement, or to pledge its credit to render it liable for any purpose or to any amount.

Section 5. Inspection of By-Laws: The corporation shall keep in its principal office for the transaction of business the original or a copy of the By-Laws as amended or otherwise altered to date, certified by the secretary, which shall be open to inspection by the members at all reasonable times during office hours.

Section 6. Rules of order: Roberts' Rules of Order shall be the parliamentary guide when not in conflict with the articles of incorporation or these By-Laws.

Section 7. Rules of Professional conduct: Principles of Professional Conduct as this corporation may adopt by a majority vote of its members shall govern this corporation and all members thereof.

Section 8. Disciplinary Action: A member who is guilty of a criminal offense or gross misconduct, either as a physician or as a citizen, or violates any of the provisions of the articles of incorporation of this corporation, or these By-Laws, or who acts contrary to or in violation of any contracts, agreements, or statements of principle of this corporation, shall be liable to censure, suspension or expulsion.

Section 9. Fiscal and Administrative Year: The fiscal and administrative year of this corporation shall begin on the first day in January and end on the last day of December of the same year commencing January 1, 1971.

CHAPTER XIII
AMENDMENTS

These By-Laws may be amended or repealed by a simple majority of those Corporate Members voting in a written ballot.

Section 2. Powers of Trustees: Subject to Section 1 of this chapter, by-laws, other than a by-law or amendment thereof changing the qualifications or classes of membership, or the authorized number of Trustees, or a chaging the powers of limitations of the Board of Trustees, may be adopted, amended, or repealed by the Board of Trustees.

Filed - DEC 22, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

Phoenix, Arizona
November 22, 1978
10:00 a.m.

DEPOSITION OF ANTHONY D. MITTEN

(VOL. I)

* * * *

[4]

* * * *

Q. Would you tell us your name and home address, please?

A. Anthony Mitten; 14851 North Skokie Court, Phoenix.

* * * *

Q. And with whom are you employed?

A. I am employed by the Maricopa County Medical Society

Q. What is your position with the Maricopa County Medical Society? A. Executive Director.

* * * *

[5]

* * * *

Q. Do you also hold a position with the Maricopa Foundation For Medical Care? A. Yes.

[6]

Q. What position do you hold?

A. Executive Director.

Q. With the Maricopa Foundation For Medical Care? A. Executive Director.

Q. What are your responsibilities in the Maricopa Foundation for Medical Care?

A. To administer the Foundation's operations.

Q. For what period of time have you been Executive Director for the Maricopa Foundation For Medical Care?

A. Let me explain something to you. They have changed titles. I have always been the chief administrator/officer of the Foundation since its inception, but the title of Executive Director did not exist at that time.

* * * *

[40]

Q. I see. Is it the ordinary practice of the Maricopa Foundation to execute agreements with insurance companies that underwrite Foundation plans?

A. Generally—we generally executed administrative agreements with underwriting companies.

* * * *

[56]

* * * *

Q. BY MS. METZGER: Paragraph 2 of Exhibit 17 states, "Since our agreement with the Insurance Advisory Committee indicated that whenever possible the Foundation would give 90 days notice of any changes in the minimum standards, these changes will be effective November 1, 1974, and are as follows," and certain information provided at the time Exhibit 17 was prepared and sent by you — did you have knowledge of such an agreement?

A. I believe that we have always had a similar type of agreement, yes. We are trying to notify the insurance people as much as possible in advance of any changes in the Minimum Standards,

[57]

with the hope that it would be at least 90 days.

Q. And would such notification normally be provided to the insurance companies?

A. Generally, yes.

Q. Was it then the normal practice of the Maricopa Foundation to send notices such as Exhibit 17 to members of the Insurance Advisory Committee?

* * * *

Q. BY MS. METZGER: Is it the ordinary course of business for Maricopa Foundation to send in writing notifications to members of the Insurance Advisory Committee of proposed increases in the Foundation Fee Schedule?

A. It is the normal course of business to have us advise underwriting companies of changes in the Foundation Minimum Standards.

Q. Would such changes in the Foundation Minimum Standards include changes in the Foundation reimbursement schedule?

[58]

A. Yes, it would.

* * * *

[60]

Q. Has the Martin E. Segal Company made any other actuarial determinations on the effect of certain Minimum Standards on Foundation plans on premium rates that would be charged for such plans?

A. I do believe that they have made some assumptions on that, yes.

* * * *

[63]

Q. BY MS. METZGER: Would the type of expertise sought by Exhibit 20 include a rough estimate of the effect on premiums charged for Foundation plans of the proposed increases in the Minimum Standards on Foundation plans?

A. Yes, it probably would include some assumption, or request some assumption from them.

* * * *

[64]

* * * *

Q. BY MS. METZGER: The court reporter has marked as Exhibit 22 a copy of a letter dated October 31, 1975, from yourself to Jack Donovan of

[65]

Blue Cross/Blue Shield. Would you review Exhibit 22 and tell us if that is a copy of the letter which you sent to Mr. Donvan?

A. I believe it is, yes.

Q. Was Exhibit 22 sent to Mr. Donovan at or near the date appearing thereon?

A. Yes.

Q. And was Exhibit 22 sent in the ordinary course of Maricopa Foundation's business?

A. Yes, it was.

Q. Was the same letter sent to other insurance companies at or about the date marked on Exhibit 22?

A. Not the same letter, no.

Q. Were letters containing the information concerning changes in the Foundation's Minimum Standards which is contained in Exhibit 22, sent to other insurance companies at or about that date?

A. I believe it was, yes.

[71]

* * * *

Q. BY MS. METZGER: Mr. Mitten, what relative value schedules are currently being used by the Maricopa Foundation?

A. The Foundation basically makes use of the 1964 California Relative Value Schedule and two or three other specialty schedules to determine the maximum reimbursement they make.

Q. Can you identify the two or three other specialty schedules that are used?

A. I believe the 1973 American Society of Anesthesiologists and there is the American College of Radiology, but I don't remember the year.

I think that's the only three that we use.

* * * *

[84]

* * * *

Q. BY MS. METZGER: Would it be correct to say, then, that Maricopa Foundation distributed to its members the 1964 edition of the California Relative Value Schedule, as prepared by the Maricopa Foundation, with instructions for use provided by the Maricopa Foundation?

A. We distributed it with our own cover and the instructions as indicated before.

Q. At approximately what date was that Relative Value Schedule distributed to the Foundation members by the Maricopa Foundation?

A. Well, at various dates.

Q. Could you tell me on what occasions the Relative Value Schedule has been distributed to the Foundation members by the Maricopa Foundation?

A. The main mailing would have been made, if I recall correctly, sometime in 1970. Subsequent mailings would have been made as a member joined — as a physician joined the Foundation.

* * * *

[88]

* * * *

Q. Do each of the Relative Value Schedules used by the Maricopa Foundations at the present time, assign relative value to services performed by doctors?

A. I don't think they are referred to in

[89]

that way.

Q. How would you refer to the numbers or values that are listed next to the procedures, or services identified, for example, in Exhibit 24?

MR. BERELSON: Off the record.

(Discussion off the record.)

A. I would say I believe there were two or three sets of numbers. The ones on the left-hand side of the column would be the identifying number, the number that would identify the procedure from a code standpoint.

The values on the other side, I think, in the terms are the most common understanding would be considered unit values, as opposed to relative values.

Q. BY MS. METZGER: Are those unit values used to determine the amounts payable for each of the procedures or services listed? A. In the '64?

Q. In any of the Relative Value Schedules used by the Foundation, is that the general way in which the Schedules are used?

MR. McAULIFFE: Used by whon.? Industrial Commission?

Q. BY MS. METZGER: Used by Maricopa Foundation?

[90]

A. Generally, with the exception of the amounts that might have shown the Minimum Standards, they would vary that number, that unit value.

Q. To determine the amount payable for a procedure listed in the Relative Value Schedule, the Foundation multiplies the unit value assigned to that procedure by the conversion factor adopted by the Foundation for that category of relative value; is that correct?

A. That would be the maximum allowable payment that we would make for that service, using the method you described, yes.

* * * *

[97]

* * * *

Q. BY MS. METZGER: Is Exhibit 28 currently being used by the Foundation as a Schedule of Unit Conversion Factors?

A. It currently is being used as a Conversion Factor for all groups, new or renewed groups, after December 1st, last year. There may be some groups that had different conversion factors prior to December 1st that are still in force.

* * * *

[114]

* * * *

Q. BY MS. METZGER: The court reporter has marked the letter dated September 30th which you referred to and it is attached to the Maricopa Foundation Fee Schedule ballot as Exhibit 31.

Was Exhibit 31 found in the files of the Maricopa Foundation?

A. Yes.

Q. And was Exhibit 31 within the custody, possession and control of the Maricopa Foundation prior to your producing it here this morning?

A. Yes, it was, I believe.

Q. Was Exhibit 31 kept in the course of

[115]

the Maricopa County Foundation's regular conducted business activities? A. Yes, it was.

Q. And is it the regular practice of the Maricopa Foundation to maintain such records in the course of their business activities? A. Yes.

Q. Was Exhibit 31 made at or near the date appearing thereon? A. Yes, I believe it was.

Q. Do you know what use the Maricopa Foundation made of the ballots which were sent to the members with Exhibit 31, which were returned to the Foundation by those members?

A. My recollection is that they used them to determine whether the membership would approve the change in the conversion factors.

Q. And did the membership approve the proposed change in the conversion factors?

A. My recollection is that they did.

Q. And the conversion factors approved by the Foundation are the conversion factors listed in Exhibit 21; is that correct?

* * * *

[117]

Q. BY MS. METZGER: Mr. Mitten, attached as part of Exhibit 31 is a Maricopa Foundation Fee Schedule ballot, or a document so entitled; are you

[118]

familiar with that ballot? A. Yes.

Q. Was that ballot sent in the form of a postcard to Foundation members? A. I can't answer that.

Q. I asked that because of the size of it.

A. It was on a card that may have been returned, addressed. It may have been just a postcard-size blank card that had to be sent back in an addressed envelope; I don't know.

Q. It is correct to say, however, that —

A. It is a ballot.

Q. That ballot was sent to members with the intention that the members return the ballot to the Foundation in the mail? A. Yes.

Q. Many of the members who were sent that ballot by the Foundation returned those ballots to the Foundation in the mail?

A. I can't give you specific numbers by recollection. Maybe the Minutes shows it. Yes, many, I suppose.

* * * *

Filed - DEC 22, 1978
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

Phoenix, Arizona
November 22, 1978
3:10 p.m.

DEPOSITION OF ANTHONY D. MITTEN

(VOL. II)

* * * *

[6]

* * * *

Q. BY MRS. METZGER: All right. Did you have occasion to transcribe or review each of the Exhibits 32 through 45 at or about the time each of those exhibits was prepared? A. Yes.

Q. May I see those, please.

On page two of Exhibit 32, which is minutes of a July 18, 1977, meeting of the Foundation board of trustees, there is reference to returns from a questionnaire sent to Foundation members. Would Exhibit 32 then be the minutes which you referred to previously as a survey of the Foundation membership?

MR. BERELSON: Let him look at it so he can see what it is.

MRS. METZGER: Sure.

A. BY THE WITNESS: I believe these would refer to the survey that was done in the Spring of

[7]

'77.

Q. BY MRS. METZGER: Thank you. Exhibit 32, page two, further records that the board directed the staff to determine what a ten percent increase in physicians' fees would do to Foundation-endorsed insurance premiums. Did you as Executive Director of the Foundation make that determination?

MR. BERELSON: Could you let him look at that.

A. BY THE WITNESS: I believe I did. Yes.

* * * *

[18]

* * * *

Q. Yes. As of today has the Fee Reimbursement Committee submitted to the Foundation or the Foundation board of trustees a report on its evaluation of the 1974 Relative Value Schedule?

A. I think there is a preliminary report in some of those minutes somewhere, board minutes somewhere.

Q. I see. Is there any other report not found in the board minutes? A. Not that I know of.

Q. Is the Fee Reimbursement Committee then evaluating the Foundation's use of the 1974 California Relative Value Schedule rather than the 1964 California Relative Value Schedule?

A. Yeah. I believe they were appointed to look at the '74 Relative Value Schedule.

* * * *

[25]

* * * *

Q. BY MRS. METZGER: Does the Maricopa Foundation have more than one committee whose responsibilities involve a Relative Value Schedule, Schedule of Conversion Factors, or other schedule or index to prices or amounts payable? A. At the present time?

Q. Yes A. Yes. I believe it would in effect have more than one committee.

Q. I see. Would one of those committees then be the Fee Reimbursement Committee concerning which you have previously testified? A. Yes.

Q. And the responsibilities of the Fee Reimbursement Committee include the evaluation of the 1974 California Relative Value Schedule for use by the Foundation in place of the 1964 California Relative Value Schedule; is that correct?

A. I believe that was one of the charges given to the committee by the board.

[87]

* * * *

Q. BY MRS. METZGER: Exhibit 61 reports that no action can be taken since the replies from the specialty societies and other information concerning fees have not been accumulated by the Foundation. Is it the normal practice of the Foundation board of trustees not to take action concerning a Relative Value Schedule until it receives replies on that subject from specialty societies?

A. Well, the action discussed was a relation to the conversion factors that might be used for the Relative Value Schedules to determine maximum

* * * *

[88]

reimbursements.

It is usual for them to wait for information that comes from outside. In this case evidently they felt the need to. In previous cases they have done different things.

Q. At the time of the board meeting, which is recorded in Exhibit 61, which is May, 1977, the Foundation was polling specialty societies regarding relative values and conversion factors to be used by the Foundation, was it not?

A. I believe they are asking the specialty societies to give them some indication of what the usual and customary changes for certain services would be.

* * * *

Filed - APR 19, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

AFFIDAVIT OF
ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being first duly sworn, deposes and says:

1. I am Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit to correct misstatements in Plaintiff's Reply Memorandum on the Effect of *Royal Drug* ("Plaintiff's Reply").

2. Plaintiff's assertion that "defendants' fee schedules fully protect the doctor from losing any money on a 'difficult case'" because "In addition to the values assigned for each medical procedure, the relative value schedules used by defendants provide for additional values to be added to the bill for any extra time, expense, service, materials or risk the doctor might incur on an individual patient" is not true. Participating physicians, other than anesthesiologists, are not additionally compensated for unexpected time expended or complexity encountered in performing a particular procedure on an individual patient. The relative values set forth in Exhibit E to Plaintiff's Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References ("Plaintiff's Statement") are based upon the time and complexity normally required for the performance of each procedure. If the cost to the physician of actual performance of a procedure exceeds its predetermined relative value, Maricopa Foundation participating physicians nevertheless agree to accept that relative value

as the basis of their maximum level of reimbursement. In cases of unusual procedures for which there is little prior experience upon which to determine a relative value, a relative value is derived by the physician's submission of a report which is subject to peer review. [Plaintiff's Statement, Ex. E, p. 9]

3. The Maricopa Foundation maximum level of compensation does not include the risk modifiers to the relative values for radiology services set forth in Exhibit F to Plaintiff's Statement on which plaintiff relies to support the foregoing incorrect assertion of fact.

4. Plaintiff's assertion that Maricopa Foundation determines anesthesiology values "by adding a 'Basic Value' which is related to the complexity of service, plus 'Modifying Units' which reflect the patient's age, physical condition and risk of complications, and 'Time Units' which reflect 'each 15 minutes or fraction thereof' the doctor spends with the patient" is not true. The method for determining the maximum level of reimbursement for anesthesiology services provided to patients insured under Maricopa Foundation-endorsed insurance programs is clearly set forth in Maricopa Foundation's Minimum Standards for Foundation-Endorsed Group Insurance Programs ("Minimum Standards"), appended as Exhibit No. MF 64 to Plaintiff's First Request for Admissions and Interrogatories.

5. The Maricopa Foundation maximum level of reimbursement for anesthesia services provided to patients insured under Maricopa Foundation-endorsed group insurance programs consists of a basic value plus time values for the time actually spent by the anesthesiologist in providing anesthesia services. Additional compensation for risk or complexity is very limited. Only "[o]*ne* risk modifier in . . . Anesthesia will be allowed for emergency cases after 6 p.m., *subject to Foundation peer review.* [Ex. No. MF 64, p. 12] (emphasis added) The Maricopa Foundation, therefore, expressly limits additional reimbursement for "risk" or

complexity to a single unit modifier for emergency cases arising after 6 p.m., and even that modification is subject to peer review of the medical necessity and appropriateness of the service provided.

6. By limiting anesthesia risk modifiers, Maricopa Foundation expressly rejected the use of risk modifiers for age and other contingencies outlined in The American Society of Anesthesiologists' Relative Value Guide 1973 ("Relative Value Guide") that is relied upon and cited by plaintiff in footnote two of Plaintiff's Reply. Maricopa Foundation participating physicians, therefore, assume the risk which would be protected against if they were reimbursed in accordance with the Relative Value Guide that plaintiff cites.

(Signature and notary clause omitted in printing.)

Filed - APR 30, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

STATE OF ARIZONA

Plaintiff,

vs.

MARICOPA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; MARICOPA FOUNDATION FOR MEDICAL CARE, and Arizona non-profit corporation; PIMA COUNTY MEDICAL SOCIETY, an Arizona non-profit corporation; and PIMA FOUNDATION FOR MEDICAL CARE, an Arizona non-profit corporation,

Defendants.

NO CIV. 78-800 PHX WPC

ORDER

Pursuant to stipulation of the parties,

IT IS ORDERED that the provisions of Paragraph 6 of the Order dated November 2, 1978 in this matter shall remain in effect pending further order of this Court.

DONE IN OPEN COURT this 20 day of April, 1979.

/s/

Honorable William P. Copple
Judge, United States District Court

Filed - JUN. 15, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

SEPARATE ANSWER OF MARICOPA COUNTY MEDICAL SOCIETY TO COMPLAINT

The Maricopa County Medical Society (hereinafter the "Society"), for its Answer to plaintiff's Complaint herein, admits, denies and alleges as follows:

I

No answer is made herein to the allegations set forth in paragraphs 8(b), 8(c), and 8(d) of the Complaint, as these allegations concern the status and conduct of defendants other than this answering defendant, and defendant lacks knowledge or information sufficient to form a belief concerning the truth thereof. No answer is made to the remaining allegations of the Complaint to the extent they concern or refer to the status, conduct, or activities of persons or entities other than this answering defendant.

II

Answering paragraph 1 of the Complaint, admits that the Complaint purports to allege violations of Section 1 of the Sherman Act, 15 U.S.C., § 1, but denies that that Act has been violated by this answering defendant, as alleged or at all. Further admits that the Complaint purports to invoke this Court's jurisdiction pursuant to the provisions of 28

U.S.C. § 1331 and 1337 and 15 U.S.C. § 26, but denies that this Court's jurisdiction has been properly invoked, as alleged or at all.

III

Answering paragraph 2 of the Complaint, denies that this Court has subject matter jurisdiction over the claims for relief set forth in Count One of the Complaint and, accordingly, denies that this Court may exercise pendent jurisdiction over the claims for relief set forth in Count Two of the Complaint.

IV

Answering paragraph III of the Complaint, admits only that this answering defendant is incorporated and maintains an office within the District of Arizona, that this Court has personal jurisdiction over this answering defendant, and that venue is properly laid in this judicial district, but denies the remaining allegations set forth in said paragraph.

V

Denies the truth of each and every allegation set forth in paragraph 4 of the Complaint.

VI

No answer is made to the allegations set forth in paragraph 5 of the Complaint as they are definitional in nature. This answering defendant does not thereby concede the validity or accuracy of any of the definitions set forth therein.

VII

Answering paragraph 6 of the Complaint, admits that the State of Arizona purports to bring this action on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona, but denies that the State of Arizona has the requisite standing to maintain this action and denies that this action may be brought by the State of Arizona as *parens patriae* as alleged or at all.

VIII

Is without knowledge or information sufficient to form a belief concerning the truth of the allegations set forth in paragraph 7 of the Complaint.

IX

Admits the allegations set forth in paragraph 8(a) of the Complaint.

X

Denies the truth of the allegations set forth in paragraph 9 of the Complaint.

XI

Answering paragraphs 10 through 13 of the Complaint, inclusive, this answering defendant is without knowledge or information sufficient to form a belief concerning the truth thereof, but denies that the activities of the defendants, as alleged in the Complaint, occurred in interstate commerce or had a direct and substantial effect upon such interstate commerce, as alleged or at all, and denies that this Court has subject matter jurisdiction over the claims for relief set forth in the Complaint.

XII

Denies the truth of each and every allegation set forth in paragraph 14 of the Complaint.

XIII

Denies the truth of each and every allegation set forth in paragraph 15 of the Complaint, and each of its subparagraphs.

XIV

Denies the truth of each and every allegation set forth in paragraph 16 of the Complaint, and each of its subparagraphs.

XV

Denies the truth of each and every allegation set forth in paragraph 17 of the Complaint, and each of its subparagraphs.

XVI

Answering paragraph 18 of the Complaint, this answering defendant repeats and realleges the allegations contained in the foregoing paragraphs of this Answer as if fully set forth herein.

XVII

Denies the truth of each and every allegation set forth in paragraph 19 of the Complaint.

XVIII

The Complaint, and each Count thereof, fail to state a claim upon which relief can be granted against this answering defendant.

XIX

This Court lacks subject matter jurisdiction over the claims for relief set forth in the Complaint, and each Count thereof.

XX

The claims for relief set forth in the Complaint, and each Count thereof, concern activities which constitute the "business of insurance" within the meaning of the McCarran-Ferguson act, 15 U.S.C. § 1011, *et seq.*, and are thus exempt from the antitrust laws.

XXI

Each allegation of the Complaint not expressly herein admitted is expressly denied.

WHEREFORE, having fully answered, defendant Maricopa County Medical Society prays that plaintiff's Complaint be dismissed and that plaintiff take nothing thereby, that defendant be awarded its costs herein incurred, and for such other and further relief as may seem just in the premises.

DATED this 15th day of June, 1979.

(Signature omitted in printing.)

Filed - JUN 15, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

ANSWER OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"), by its undersigned attorneys, answers the complaint herein as follows:

1. Denies each and every averment of paragraph 1 except admits that plaintiff purports to bring this action and to invoke the jurisdiction of this Court pursuant to the statutory provisions cited therein.

2. Denies each and very averment of paragraphs 2, 4, 9, 14, 15 and each subparagraph thereof, 16 and each subparagraph thereof, 17 and each subparagraph thereof, and 19.

3. Denies each and every averment of paragraph 3, except states that it is without knowledge or information sufficient to form a belief as to the truth of the averments with respect to defendants Pima County Medical Society ("Pima

Society") and Pima Foundation for Medical Care ("Pima Foundation"), admits that plaintiff purports to lay venue in this District pursuant to the statutory provisions cited therein and that Maricopa Foundation and Maricopa County Medical Society ("Maricopa Society") are each incorporated, each maintains an office, and each transacts business within the District of Arizona.

4. Admits that plaintiff purports to define the terms set forth in subparagraphs (a)-(i) of paragraph 5 for use in the complaint, states that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained therein and denies that the terms have been defined in accordance with commonly accepted usage.

5. Denies the averments of paragraph 6 except admits that plaintiff purports to bring this action on its own behalf and as *parens patriae* on behalf of the citizens of the State of Arizona.

6. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments of paragraph 7 except denies that plaintiff and citizens of Arizona have been and continue to be injured by the violations of the antitrust laws alleged in the complaint.

7. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in subparagraphs (c) and (d) of paragraph 8 and denies each and every averment contained in subparagraph (b) of paragraph 8 except admits that it is an Arizona nonprofit corporation with its principal place of business in Phoenix, Arizona, that it has four classes of membership, that the Executive Director of the Maricopa Society is also its Executive Director, and states that every person, upon becoming a member of the Board of Directors of the Maricopa Society is entitled to become, and, without further action or proceeding, becomes an administrative member of it, and states that it is without knowledge or information sufficient to form a belief as to the truth of the averment

that over 70 percent of the doctors practicing in Maricopa County are participating or cooperating members of the Maricopa Foundation.

8. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in paragraph 10.

9. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in paragraph 11 except denies that doctors in Arizona prescribe medicines and other goods and products which are shipped in interstate commerce and form an integral part of the interstate distribution of such prescription drugs, goods and products and that the practice of medicine involves the purchase, use and sale of goods and products which are manufactured and sold and flow in a continuous and uninterrupted stream of interstate commerce.

10. States that it is without knowledge or information sufficient to form a belief as to the truth of the averments of paragraph 12 except denies that health insurance involves a continuous and uninterrupted flow of services, products, contracts and claims in interstate commerce.

11. Denies each and every averment of paragraph 13 with respect to it except admits it endorses health insurance plans and it will not endorse a health insurance plan unless it meets minimum standards for Foundation-endorsed group insurance programs formulated by it or it agrees in writing to a modification of those standards, and that some plans endorsed by it are underwritten by private insurers, each such private insurer doing business from a location in Arizona and at least some doing business from locations outside Arizona and states that it is without knowledge or information sufficient to form a belief as to the truth of the averments contained in paragraph 13 with respect to the Pima Foundation.

12. Maricopa Foundation repeats and realleges its answers to paragraphs 1 through 17 of the complaint in the same manner and to the same extent as though each answer were again set forth in full.

FIRST AFFIRMATIVE DEFENSE

13. The complaint fails to state a claim against Maricopa Foundation upon which relief can be granted against it.

SECOND AFFIRMATIVE DEFENSE

14. The Court lacks jurisdiction over the subject matter alleged in the complaint.

THIRD AFFIRMATIVE DEFENSE

15. The claims set forth in the complaint are barred by the doctrine of unclean hands.

FOURTH AFFIRMATIVE DEFENSE

16. The claims set forth in the complaint are barred by plaintiff's wilful failure to comply with the requirements of A.R.S. §§ 44-1401 *et seq.*

FIFTH AFFIRMATIVE DEFENSE

17. The claims set forth in the complaint are barred by the doctrine of laches.

SIXTH AFFIRMATIVE DEFENSE

18. Plaintiff is estopped from pursuing the claims set forth in the complaint.

SEVENTH AFFIRMATIVE DEFENSE

19. The claims set forth in the complaint concern activities which constitute the business of insurance which is exempt from the antitrust laws pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*

WHEREFORE, Maricopa Foundation demands judgment dismissing the complaint with prejudice, together with its costs and disbursements incurred herein and for such other and further relief as is appropriate.

June 18, 1979.

(Signature omitted in printing.)

Filed - JUN 27, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MOTION OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE TO VACATE TEMPORARY RESTRAINING ORDER OF APRIL 30, 1979 AND NOTICE OF SUBMISSION WITHOUT A HEARING

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") moves the Court, pursuant to Rule 65(b) of the Federal Rules of Civil Procedure, to vacate its Order entered April 30, 1979 extending indefinitely the effectiveness of the temporary restraining order contained in Paragraph 6 of the Order dated November 2, 1978 on the grounds that: (1) Maricopa Foundation only stipulated to extend that temporary restraining order for three weeks beyond the Court's determination of the motions decided by the Court on June 5, 1979; (2) Maricopa Foundation will be severely prejudiced by the continuation of that order; (3) plaintiff has not carried its burden of showing the threat of irreparable injury to justify the issuance of a preliminary injunction; (4) plaintiff has not carried its burden of demonstrating probability of success on the merits, and; (5) plaintiff has failed to give security, all of which more fully appear in the accompanying memorandum submitted in support of this motion. Alternatively, Maricopa Foundation moves that plaintiff be required to give security pursuant to Rule 65(c) of the Federal Rules of Civil Procedure.

Please take notice that this motion is submitted pursuant to Local Rule 11(f) without a hearing.

(Signatures omitted in printing.)

File - JUN 27, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MOTION TO VACATE TEMPORARY RESTRAINING ORDER OF APRIL 30, 1979

PRELIMINARY STATEMENT

On April 30, 1979, this Court extended indefinitely the temporary restraining order contained in Paragraph 6 of its Order dated November 2, 1978.* Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") now moves the Court to vacate that order pursuant to Rule 65(b) of the Federal Rules of Civil Procedure on the grounds that: (1) Maricopa Foundation has not stipulated to any extension of the temporary restraining order beyond June 26, 1979; (2) Maricopa Foundation will be severely prejudiced by the continuation of that order; (3) plaintiff has not carried its burden of showing irreparable injury necessary to justify a continuation of the restraint; (4) plaintiff has not carried its burden of demonstrating probability of success on the merits, and; (5) plaintiff has failed to give security as required by Fed. R. Civ. P. 65(c). To permit Paragraph 6 of the November 2 Order to remain in

---

*Paragraph 6 provides:

For the purpose of maintaining the status quo until plaintiff's preliminary injunction motion may be heard, until the earlier of May 1, 1979, or final judgment for any party in this action, or further order of this Court, no defendant, nor any officer, agent, servant, employee or attorney of any defendant nor any person in active concert or participation with any defendant who receives actual notice of this order by personal service or otherwise shall participate in any survey, agreement, vote or other step to establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and conversion factors in effect on or before October 18, 1978.

effect constitutes the *de facto* issuance of a preliminary injunction without plaintiff having made the required showing of entitlement to such relief pursuant to Rule 65(a).

ARGUMENT

THE COURT'S NOVEMBER 2, 1978 TEMPORARY RESTRAINING ORDER CANNOT BE CONVERTED INTO A PRELIMINARY INJUNCTION WITHOUT ANY SHOWING BY PLAINTIFF OF ENTITLEMENT TO SUCH EXTRAORDINARY RELIEF.

1. Because Maricopa Foundation Never Stipulated to an Extension of the Temporary Restraining Order Beyond June 26, 1979, Plaintiff Cannot Simply Treat the Order as an Open-Ended Preliminary Injunction.

In its Motion for Extension of Temporary Restraining Order filed on April 20, 1979, plaintiff represented to the Court that the parties had been unable to agree upon a stipulated extension of the temporary restraining order which by its terms expired May 1, 1979. In fact, defendants had offered to stipulate to an extension of Paragraph 6 of the November 2 Order for three weeks after the Court's decision if the Court denied the then pending motions to dismiss. (Maricopa Foundation For Medical Care's Response to Plaintiff's Motion for Extension of Temporary Restraining Order, at 2 (April 25, 1979).) Not content with anything short of open-ended injunctive relief, this offer was rejected by plaintiff.

Apparently realizing that the April 30 Order gives it the equivalent of a preliminary injunction, plaintiff no longer presses for a hearing on its pending application for an order to show cause. At the Rule 42A conference held on Thursday, June 21, 1979, plaintiff's counsel represented that plaintiff intended to move for reconsideration of this Court's June 5, 1979 Order, or in the alternative, certification of that ruling pursuant to 28 U.S.C.A. § 1292(b), or alternatively for summary judgment under the rule-of-

reason standard applicable to the practices challenged in this case. Although declining to stipulate to a vacation of the April 30 Order, plaintiff did not disclose any intention to move forward with a hearing on its motion for a preliminary injunction.* Furthermore, any preliminary injunction hearing would necessarily be delayed because plaintiff has yet to respond fully to defendant's outstanding discovery requests and to date has not even stated when its responses will be forthcoming.

Under the circumstances, plaintiff has simply ignored *its* burden of showing entitlement to a preliminary injunction, choosing instead to treat the order as having already issued. Rule 65(b), however, prohibits any such effect being attributed to the extension of the temporary restraining order absent the consent of the Maricopa Foundation. And the Maricopa Foundation has *not* consented to any such extension.

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* Plaintiff cannot have it both ways. It is well-established that an order extending a TRO beyond the time limits permitted by Fed. R. Civ. P. 65(b) is treated like a preliminary injunction, *National City Bank v. Battisti*, 581 F.2d 565, 568 (6th Cir. 1977) ("Upon examination of the entire record this court concludes that the motion of the various parties . . . for extension of the injunctive provisions of the November 4th order should be treated as a motion for a preliminary injunction, and the November 18th order of the district court was in effect a preliminary injunction which was intended to extend and enlarge the injunctive provisions of the temporary restraining order of November 4th and was intended to make the injunctive provisions effective beyond the time permitted under a temporary restraining order by Rule 65(b)"); therefore, without a hearing, the issuance of findings of fact and conclusion of law and the giving of security, the validity of the order is questionable. *Granny Goose Foods, Inc. v. Brotherhood of Teams, Etc.*, 415 U.S. 423, 443 n.17 (1974) ("Where a temporary restraining order has been continued beyond the time limits permitted under Rule 65(b), and where the required findings of fact and conclusions of law have not been set forth, the order is invalid").

2. The Harm to Maricopa Foundation and the Absence of Any Showing of Irreparable Injury to Plaintiff Are Sufficient Grounds to Vacate the Temporary Restraining Order.

The provisions of Paragraph 6 of the November 2 Order, as continued in effect by the Court's April 30 Order, prohibit the Maricopa Foundation from taking any steps to alter the maximum level of reimbursement payable to physicians for services rendered to patients insured under Foundation-endorsed health insurance plans. Defendant has not adjusted its maximum level of reimbursement since December 1, 1977. (Affidavit of Anthony D. Mitten, para. 3, annexed hereto as Exhibit "A".) During this period, increasing costs to participating physicians have rendered it uneconomical for them to continue to provide services to subscribers of Foundation-endorsed plans at the current maximum levels of reimbursement; in fact, many physicians have expressed an unwillingness to continue their participation absent a revision in the maximum level of reimbursement.* (*Id.*, para. 4.) As a result, the viability of the Foundation is threatened by its inability to offer fair and reasonable reimbursement to the providers of services to Foundation-plan subscribers. Additionally, the Foundation cannot negotiate renewal of outstanding agreements due to expire with the underwriters of its plans or with existing groups when there is a serious question concerning continued physician participation. (*Id.*, para. 5.) This threat to defendant's economic viability by itself is sufficient grounds to vacate the continuing restraint on the Maricopa Foundation. *Democratic Cent. Com. of D.C. v. Washington Met. A.T. Com'n*, 436 F.2d 233, 235 (D.C. Cir. 1970)

* It cannot be doubted that *if* physicians resign due to the prevailing low reimbursement levels applicable to Foundation-endorsed plans, the cost of medical care to those otherwise covered by Foundation-endorsed plans will necessarily increase when the constraint of Foundation reimbursement levels is removed. It follows that the public interest is not served by an order that in effect forces the public to pay *more* for health care.

(declining to stay an order authorizing a fare increase by the D.C. Transit System, Inc., the court stated that "[w]e, however, cannot ignore the prospect, to which the record lends credence, that the increases are essential to Transit's continued existence, nor can we treat lightly the serious constitutional question that denial of the increases would pose in the circumstances").

In contrast to the obvious harm to Maricopa Foundation from the continuation of the temporary restraining order, plaintiff has not and cannot show the threat of irreparable injury necessary to warrant the issuance of a preliminary injunction. The *only* injuries alleged by plaintiff in Paragraph VIII of the Complaint are higher prices which, if shown, might conceivably be compensable by money damages. By definition, such alleged injury is not irreparable and thus not a sufficient basis for the award of temporary or preliminary injunctive relief even where plaintiff alleges the amount of damage is substantial.* *SCM Corp. v. Xerox Corp.*, 507 F.2d 358, 360, 363 (2d Cir. 1974) (affirming denial of preliminary injunction because plaintiff had not shown irreparable injury where it claimed damages of threefold the amount of $145,000,000, court stated that plaintiff "admittedly cannot escape its burden of establishing the threat of irreparable harm. The statute [Section 16 of the Clayton Act] so requires and we are not free to disregard it. Indeed, the flaw in the SCM case here is its continuing failure to supply proof of a threat of irreparable

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* Plaintiff asserted in support of its application to require defendants to post a bond that a continuation of the subject practices would result in substantial damages to the citizens of Arizona. (Memorandum in Support of Motion to Vacate or Modify Stay Order of December 27, 1978, at 17-18 (January 12, 1979).) Accepting arguendo the grossly inflated figures put forth by plaintiff, still the only "damage" claimed by plaintiff is calculable and compensable. It should be noted that on a per capita basis the figure is *de minimis*. Moreover, even were the prospect of future money damages a form of irreparable harm, any increase in maximum levels of reimbursement would not be effective until January 1, 1980, undermining any claims by plaintiff that relief *pendente lite* is necessary (Affidavit of Anthony D. Mitten, para. 5).

harm. [I]t is basic that equitable relief will not be granted where an adequate remedy at law exists. Money damages . . . constitute such an adequate remedy").

To summarize, plaintiff cannot make out the indispensible predicate to injunctive relief—irreparable harm. On the other hand, Maricopa Foundation is directly and seriously prejudiced by the temporary restraining order not only in terms of immediate financial loss but in terms of a real threat to its continued existence. The harm to defendant from contination of the temporary restraining order surely outweighs any alleged but unproved irreparable injury to plaintiff.

3. Because Maricopa Foundation's Conduct Is to Be Tested Under the Rule of Reason, Plaintiff Has Not Demonstrated Likelihood of Success on the Merits.

Equally fatal to any effort by plaintiff to secure a *de facto* preliminary injunction through extension of the November 2 Temporary Restraining Order is its inability to show a reasonable likelihood of success on the merits. In its Order of June 5, 1979, denying plaintiff's motion for summary judgment, this Court concluded that "the Rule of Reason approach should be used in analyzing the challenged conduct in the instant case." (Memorandum and Order at 12.) The Court further stated that plaintiff would be required to present sufficient evidence "as to the purpose and effect of the allegedly unlawful practices and the power of the defendant." *Id.*

As a result of the Court's ruling, the predicate underlying plaintiff's motion for a preliminary injunction has vanished. In support of its motion, plaintiff argues that the "clarity of this *per se* rule" demonstrates the "strong probability that plaintiff will succeed in the merits." (Memorandum in Support of Order to Show Cause and Motion for Preliminary

Injunction, at 12 (Oct. 25, 1978).) The factual inquiries now mandated under the Court's ruling eliminate plaintiff's simplistic assessment of the ultimate outcome of the litigation.

Antitrust cases involving conduct tested by the Rule of Reason are particularly unsuited to the issuance of temporary or preliminary injunctive relief restraining the challenged practice. *Fuchs Sugar & Syrups, Inc. v. Amstar Corporation*, 380 F. Supp. 441, 444 (S.D.N.Y. 1974) (denying motion for preliminary injunction, the court stated "[T]he Court is not convinced that Amstar's actions constitute a scheme to fix prices, which would be *per se* illegal, but rather sees numerous factual and legal questions.... It does not yet clearly appear to this Court that defendant has acted with the purpose or the effect of reducing competition or unlawfully extending a monopoly position in the market"); *see Heldman v. United States Lawn Tennis Ass'n*, 354 F. Supp. 1241, 1250 (S.D.N.Y. 1973) (no reasonable probability of ultimate success where "there are close and complex issues raised—particularly with regard to the antitrust allegations—which should only be resolved upon a full trial of the facts"); *Jones v. National Collegiate Athletic Ass'n*, 392 F. Supp. 295, 304 (D.Mass. 1975) (court found no substantial likelihood of success to warrant preliminary injunctive relief, stating: "In order to make out a group boycott claim the plaintiff must allege that the defendant's purpose was to exclude a person or group from the market or accomplish some other anticompetitive objective. The issue in group boycott cases then is not merely the existence or nonexistence of a concerted refusal to deal, but rather whether the association was designed to exclude outsiders from participation in the marketplace"). Because the Court has now determined that the Rule of Reason test will be applied in this case, it would simply be an exercise in conjecture for plaintiff to contend that it will ultimately prevail on the merits before the facts have been fully developed. Application of the Rule of Reason gives rise to complex issues whose resolution is most

appropriately left for trial. In advance of trial, no informed and reasoned showing can be made by plaintiff that a determination of these issues will be in its favor. The Order of April 30, 1979 should therefore be vacated.

4. If the Order of April 30, 1979 Is Not Vacated, Its Continuation Should Be Conditioned Upon Plaintiff's Giving Security as Required Under the Federal Rules of Civil Procedure.

While plaintiff has repeatedly characterized Paragraph 6 of the November 2 Order as injunctive relief,* it has conveniently ignored Fed. R. Civ. P. 65(c) which requires a party obtaining a temporary restraining order or preliminary injunction to give security in the event that the restrained party is found to have been wrongfully enjoined. Rule 65(c) is, by its terms, mandatory, declaring in pertinent part:

> *No* restraining order or preliminary injunction *shall issue* except upon the giving of security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained.* (Emphasis added.)

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*See, *e.g.*, Memorandum in Support of Motion to Vacate or Modify Stay Order of December 27, 1978, at 17 (Jan. 12, 1979) ("The stay order should certainly be clarified to preserve the prohibitory injunction of Paragraph 6 of the November 2, 1978 Order").

*C. Wright & A. Miller, *Federal Practice and Procedure* § 2954, at 524:

> Although it is settled that security need not be posted at the time interlocutory injunctive relief is applied for, the rule is phrased in mandatory terms and the conclusion seems inescapable that once the court decides to grant equitable relief under Rule 65 it must require security from the applicant. In fact, a district court's failure to require the posting of a bond or other security has been held reversible error.

Section 16 of the Clayton Act, 15 U.S.C.A. § 26, similarly provides that an injunction shall not issue except "upon the execution of proper bond against damages for an injunction improvidently granted."

The Court does, of course, have discretion with respect to the *amount* of the security that will be required. In this regard, "the judge usually will fix security in an amount that covers the potential incidental and consequential costs and ... the losses the unjustly enjoined or restrained party will suffer during the period he is prohibited from engaging in certain activities. ..." C. Wright & A. Miller *Federal Practice and Procedure* § 2954, at 525. Plaintiff has itself furnished to the Court its calculation of the amount of the loss which defendant will suffer by virtue of continuing the temporary restraining order. In its Motion to Vacate or Modify Stay Order of December 27, 1978, at 17 (Jan. 12, 1979), plaintiff calculates those losses at $1.8 million per month. Therefore, if the Court does not vacate the temporary restraining order, Maricopa Foundation submits that plaintiff should be required to post a bond in favor of Maricopa Foundation sufficient to cover the losses accruing to Maricopa Foundation at the rate of $1.8 million per month for so long as the Court permits a temporary restraining order or preliminary injunction to remain in effect.

Conclusion

For the foregoing reasons, defendant Maricopa Foundation submits that the Court's Order of April 30, 1979 should be vacated or, in the alternative, that plaintiff should be required to give security in an amount to be determined by the Court but not less than $1.8 million per month for so long as the Court permits a restraining order or preliminary injunction to remain in effect.

(Signature omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

Anthony D. Mitten, being first duly sworn, under oath, deposes and say:

1. I am the Executive Director of defendant Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit in support of Maricopa Foundation's Motion to Vacate the Temporary Restraining Order of April 30, 1979.

2. On or about November 2, 1978, Maricopa Foundation stipulated to the entering of an order whereby it agreed to refrain until no later than May 1, 1979 from "participat[ing] in any survey, agreement, vote or other step to establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and converison factors in effect on or before October 18, 1978." [Stipulation dated November 2, 1978, para. 6] Prior to the filing of Plaintiff's Motion for Extension of Temporary Restraining Order on April 20, 1979, Maricopa Foundation offered to stipulate to extend that order three weeks beyond determination of the Rule 12 motions then pending. The stipulation of November 2, 1978 and offer to extend the stipulation in April 1979 were made in good faith and were based upon Maricopa Foundation's best judgment as to the length of time during which it could agree to maintain the status quo without jeopardizing its economic viability and, hence, its ability to serve as a competitive alternative in the providing of health care services in Maricopa County, Arizona.

3. Maricopa Foundation presently compensates physicians who provide services to patients insured under Marico, Foundation endorsed insurance programs in accordance with a maximum level of reimbursement that was effective as of December 1, 1977. Maximum levels or reimbursement to Maricopa Foundation members for treating patients insured under Maricopa Foundation endorsed health insurance plans have remained the same for a period of nearly two years, despite the high general rate of inflation in the national economy.

4. Increasing numbers of Maricopa Foundation members have requested that they be allowed to terminate their memberships because the Maricopa Foundation's current maximum levels of reimbursement in many cases do not adequately compensate physicians for the services they provide.

5. In order for Maricopa Foundation to maintain its membership and to continue to provide a competitive health care alternative, it is imperative that it be permtted to establish new maximum levels of reimbursement (to be effective no sooner than January 1, 1980) upon which to base negotiations for the renewal of outstanding agreements with employee groups and underwriters which shall expire on or before December 31, 1979. If the Maricopa Foundation is not permitted to negotiate contracts on the basis of new maximum levels of reimbursement, its economic viability will be seriously threatened and it will be irreparably damaged.

(Signature and notary clause omitted in printing.)

Filed - JUN 29, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MOTION OF DEFENDANT PIMA FOUNDATION FOR MEDICAL CARE TO VACATE TEMPORARY RESTRAINING ORDER OF APRIL 30, 1979, AND NOTICE OF SUBMISSION WITHOUT A HEARING

The defendant, Pima Foundation for Medical Care (Pima Foundation), appears and joins with the Maricopa Foundation for Medical Care in that defendant's Motion to vacate the Court's Order of April 30, 1979, on the grounds and for the reasons set forth in the moving papers of the defendant, Maricopa Foundation, and the affidavit of Thomas P. Finley, the Executive Director of the Pima Foundation for Medical Care, attached hereto and made a part hereof.

This motion is also submitted pursuant to Local Rule 11(f) without a hearing.

(Signature omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF THOMAS P. FINLEY

STATE OF ARIZONA }
} ss.
County of Pima }

Thomas P. Finley, being first duly sworn, under oath, deposes and says:

1. That I am the Executive Director of Defendant Pima Foundation for Medical Care (Pima Foundation). I make this affidavit in support of Pima Foundation's Motion to Vacate the Temporary Restraining Order of April 30, 1979.

2. On or about November 2, 1978, Pima Foundation stipulated to the entering of an order whereby it agreed to refrain until no later than May 1, 1979, from "participat[ing] in any survey, agreement, vote or other step to establish, determine or disseminate any relative value or conversion factor with respect to medical services, goods or products other than those relative values and conversion factors in effect on or before October 18, 1978." (Stipulation dated November 2, 1978, para. 6). Prior to the filing of Plaintiff's Motion for Extension of Temporary Restraining Order on April 20, 1979, Pima Foundation offered to stipulate to extend that order three weeks beyond determination of the Rule 12 motions then pending. The stipulation of November 2, 1978, and offer to extend the stipulation in April, 1979, were made in good faith and were based upon Pima Foundation's best judgment as to the length of time during which it could agree to maintain the status quo without jeopardizing its economic viability and, hence, its ability to serve as a competitive alternative in the providing of health care services in Pima County, Arizona.

3. Pima Foundation presently compensates physicians who provide services to patients insured under Pima Foundation endorsed insurance programs in accordance with a maximum level of reimbursement that was effective as of December 1, 1977. Maximum levels of reimbursement to

Pima Foundation members for treating patients insured under Pima Foundation endorsed health insurance plans have remained the same for a period of nearly two years, despite the high general rate of inflation in the national economy.

4. Increasing numbers of Pima Foundation members have requested that they be allowed to terminate their memberships because the Pima Foundation's current maximum levels of reimbursement in many cases do not adequately compensate physicians for the services they provide.

5. In order for Pima Foundation to maintain its membership and to continue to provide a competitive health care alternative, it is imperative that it be permitted to establish new maximum levels of reimbursement (to be effective no sooner than January 1, 1980) upon which to base negotiations for the renewal of outstanding agreements with employee groups and underwriters which shall expire on or before December 31, 1979. If the Pima Foundation is not permitted to negotiate contracts on the basis of new maximum levels of reimbursement, its economic viability will be seriously threatened and it will be irreparably damaged.

(Signature and notary clause omitted in printing)

Filed - JUL 11, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

NO. CIV. 78-800 PHX-WPC
MEMORANDUM AND ORDER

Defendants Maricopa Foundation for Medical Care and Pima Foundation for Medical Care have moved to vacate the order of the Court dated April 30, 1979, which continued until further order the temporary restraining order contained in Paragraph 6 of the order dated November 2, 1978. The defendants have established irreparable injury to themselves by substantiating without dispute through affidavits that participating physicians have threatened to withdraw from the defendant foundations. The plaintiff, on the other hand, has failed to show injury to itself and those it represents that cannot be compensated by money damages or that could be avoided if the motion to vacate the temporary restraining order were denied. The plaintiff has also not demonstrated that the injury to it in granting the motion exceeds that incurred by defendants in denying the motion. The plaintiff, moreover, has not shown that it is likely to succeed on the merits based on the Rule-of-Reason approach adopted here, which requires relatively complex factual inquiries. Thus, whether treated as a motion to va-

cate the temporary restraining order, or, because of the lapse of time and the preparation of the parties, as an application for a preliminary injunction, the defendants are entitled to relief. Therefore,

IT IS ORDERED:

The defendants' motion to vacate the April 30, 1979, temporary restraining order is granted.

DATED July 17, 1979.

/s/
United States District Judge

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

Plaintiff STATE OF ARIZONA moves pursuant to Rule 56(a), Federal Rules of Civil Procedure, for entry of an order awarding summary judgment in its favor and against defendants that defendants' combination and conspiracy and acts done in pursuance thereof were and are an unreasonable restraint of trade and commerce in violation of section 1 of the Sherman Act, 15 U.S.C. § 1, and the Uniform State Antitrust Act, Ariz. Rev. Stat. Ann. § 44-1402, under the Rule of Reason standard, and permanently enjoining defendants and their members from continuing those activities and from entering into any combination, conspiracy, agreement, understanding or concert of action having a similar purpose or effect.

In the event summary judgment is not rendered fully on this motion as prayed, plaintiff respectfully requests in the alternative that the Court enter an order pursuant to Rule 56(d), Federal Rules of Civil Procedure, specifying the facts that appear without substantial controversy and the issues of fact and law that remain to be tried and directing further proceedings in this matter including the hearing of plaintiff's motion for preliminary injunction.

This motion is based upon section 1 of the Sherman Act, 15 U.S.C. § 1, section 16 of the Clayton Act, 15 U.S.C. § 26, the Uniform State Antitrust Act, Ariz. Rev. Stat. Ann. §§ 44-1402, 44-1408, Rule 56, Federal Rules of Civil Procedure, the entire record in this matter and the accompanying statement of undisputed facts and memorandum of law.

DATED: July 6, 1979.

(Signature omitted in printing.)

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

I.
INTRODUCTION

Plaintiff State of Arizona previously moved on November 20, 1978 for partial summary judgment on the issue of liability in this matter, basing its legal argument primarily upon the *per se* standard of liability. Having determined that the Rule of Reason approach should be used in analyzing the conduct at issue in this case, this Court denied plaintiff's motion of November 20, 1978, with leave to file a similar motion based upon the Rule of Reason standard (Memorandum and Order of June 5, 1979).[1] Plaintiff readily accepts that invitation and respectfully requests that the Court enter its order granting summary

[1] Plaintiff has respectfully requested in a separate motion filed concurrently with this motion for summary judgment and permanent injunction that this Court reconsider and vacate its Memorandum and Order of June 5, 1979, insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability based upon the conclusion that the *per se* standard of analysis does not apply to price-fixing by a professional trade association, and that it grant plaintiff's motion for partial summary judgment on the issue of liability. Alternatively, that motion requests this Court to enter its order pursuant to 28 U.S.C. § 1292(b) that insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability the Memorandum and Order of June 5, 1979 involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from that portion of the order may materially advance the ultimate termination of the litigation. Plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, or alternatively, Motion for Certification for Interlocutory Appeal Pursuant to 28 U.S.C. § 1292(b) of Memorandum and Order of June 5, 1979.

judgment in plaintiff's favor and against defendants that the conduct of defendants alleged by plaintiff and established by the record in this case is in violation of section 1 of the Sherman Act and Arizona's Uniform State Antitrust Act under the Rule of Reason standard, and providing permanent injunctive relief from the continuation of such conduct. In the alternative plaintiff respectfully requests that the Court make an order pursuant to Rule 56(d), Federal Rules of Civil Procedure, specifying the facts that appear without substantial controversy and the issues of fact and law that remain to be tried, and directing further proceedings in this matter including the hearing of plaintiff's motion for preliminary injunction.

"The inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 691, 98 S. Ct. 1355, 1365 (1978). In this case, the undisputed evidence establishes that the defendant foundations function as doctors' cartels whose members adopt by majority vote the prices they will accept for services rendered to individual patients on a fee-for-service basis. It is undisputed that the price-fixing activities at issue here are entirely horizontal in nature, as the agreed-upon price increases and uniform fee schedules adopted by the defendants are determined by a majority vote of defendants' doctor members not the insurers and other third parties that pay for doctors' services in accordance with the foundation fee schedules.

That the horizontal price-fixing activities of these doctors' cartels has been patently anticompetitive both in purpose and effect is amply documented in the record. Whatever procompetitive benefits the defendants might assert could be achieved by far less anticompetitive procedures than those at issue here. *See Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1183-1189 (D.C. Cir. 1978); *Mackey v. National Football League*, 543 F.2 606, 620-622 (1976).

Because the undisputed facts in this matter reveal that defendants' price-fixing activities have been far more restrictive than necessary to serve any legitimate purpose, summary judgment is appropriate under the Rule of Reason standard. *E.g., Associated Press v. United States*, 326 U.S. 1, 65 S. Ct. 1416 (1945); *Kapp v. National Football League*, 390 F. Supp. 73, 82-83 (N.D. Cal. 1974), *aff'd*, 586 F.2d 644 (9th Cir. 1978); *see National Society of Professional Engineers*, 435 U.S. at 691-92, 98 S. Ct. at 1365-66; *Silver v. New York Stock Exchange*, 373 U.S. 341, 345, 360-61, 83 S.Ct. 1246, 1251, 1259 (1963).

II.

SUMMARY OF THE FACTS[2]

A. The Defendants

It is undisputed that each of the defendants is an association of doctors[3] who are licensed to practice in the State of Arizona (Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction (hereinafter "Statement of Facts" No. 1). The defendant medical societies are the local components of the American Medical Association in Maricopa and Pima Counties. (Statement of Facts No. 8.) Having founded the defendant foundations to promote the interests of fee-for-service medicine, the defendant societies have con-

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[2] The undisputed facts upon which this motion for summary judgment is based are set forth in detail with citations to the record in the accompanying Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction and summarized here with references to that Statement.

[3] Medical and osteopathic physicians and surgeons and podiatrists who practice in Pima County or a county contiguous to Pima County may qualify for membership in the Pima Foundation for Medical Care ("Pima Foundation"). Medical and osteopathic physicians and surgeons may qualify for participating membership, and podiatrists and oral surgeons may qualify for cooperating membership, in the Maricopa Foundation for Medical Care ("Maricopa Foundation") no matter where in the State of Arizona they practice. The term "doctors" is used inclusively to refer to all foundation members.

trolled the activities of the foundations, including the activities at issue here.[1] (Statement of Facts Nos. 2,3.)

Defendants have repeatedly represented that their membership includes a substantial percentage of the fee-for-service physicians in their respective communities. (Statement of Facts No. 4). For example, in a bid dated May 18, 1979, the Maricopa Foundation represented that:

> The Maricopa Foundation for Medical Care was incorporated in 1969 and initially enrolled 80 percent of the active private practicing physicians in Maricopa County as participating members.
>
> There are approximately 1500 active practicing M.D.'s available to private patients and 250 Osteopathic physicians in Maricopa County. The Foundation has consistently maintained over 70% of the private practicing M.D.'s and approximately one-half of the Osteopathic physicians as members. The majority of the Podiatrists in Maricopa County also participate in the Foundation organization. (Exhibit to Affidavit of Alice McLain, dated July 5, 1979, Exhibit V to Statement of Facts.)

At the present time, over 1,000 of the licensed doctors in Maricopa County and over 400 of the licensed doctors in Pima County are members of the defendant foundations.

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[1] Under the By-Laws of both of the defendant foundations, the elected directors of the defendant societies have also served as the administrative members of the defendant foundations. In that capacity, the societies' directors have had the only general voting power on foundation affairs and have selected the foundations' trustees. (Statement of Facts.)

The Pima County Medical Society ("Pima Society") severed its relationship with the Pima Foundation in October, 1978, after the complaint in this action had been filed, and a consent judgment was thereafter entered against the Pima Society on November 17, 1978. The trustees of the Pima Foundation are now elected by the members of that foundation.

(Statement of Facts Nos. 31 and 32.) Thus, a substantial portion of the providers of fee-for-service medicine in Maricopa and Pima Counties have been involved in the practices at issue here.

B. Purpose

Defendants concede that the foundations were established by the defendant societies to promote the interests of fee-for-service medicine (Statement of Facts Nos. 3, 4), the dominant form of medical practice in which individual providers of doctors' services are paid on the basis of the particular services they render to individual patients.[8] In repeated communications to their members and other physicians, the defendant foundations have emphasized that they have been working to protect the interests of physicians who practice on a fee-for-service basis. (Statement of Facts No. 4, 36.)

A primary function of the defendant foundations since their inception has been the preparation and adoption of "uniform fee schedules" for doctors' services. Indeed, the only power granted to the members of either of the defendant foundations under the By-Laws of those associations has been the power "to vote on the adoption of . . . uniform fee schedules . . . by mail ballot." (Statement of Facts Nos. 12, 13.) The By-laws of both groups have also called for the establishment of standing fee schedule committees and have specifically authorized the foundations' trustees "to

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[8] *See American Medical Association v. United States*, 317 U.S. 519, 536, 63 S. Ct. 326, 332 (1943). Doctors who practice on a fee-for-service basis may practice alone or in a partnership or corporation with several other doctors. The key factor in fee-for-service practice is that the doctor (or his partnership or corporation) functions as an independent unit and is paid by the individual patient (or a third party which has assumed responsibility for that patient's doctor bills) on the basis of the services sold to the individual patient (rather than being paid a flat rate or a salary). *See generally, Council on Wage and Price Stability, Physicians Fees, A Study of Physicians' Fees* (1978) (Exhibit 2 to the Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References).

adopt and to propose to the [membership] uniform fee schedules for medical services" which when adopted by the majority vote of the [membership have been] binding upon all [members]." (Statement of Facts Nos. 13, 14, 20 & 21.) Doctors who apply for membership in the foundations have been required to complete and sign application blanks which contain an agreement "to be bound by any and all rules, regulations, committee decisions, fee schedules and the like, adopted by [the foundation]. (Statement of Facts Nos. 14, 22, 30, 34.)

In addition to determining the amounts which insurers must pay for professional services, the minimum standards promulgated by the defendant foundations have expressly limited the "professional payments" made under foundation-approved plans to "duly licensed (a) Physicians and Surgeons, (Doctors of Medicine), (b) Doctors of Dentistry, (c) Physicians and Surgeons (Doctors of Osteopathy), [and] (d) Doctors of Chiropody (Podiatrists)." (Statement of Facts No. 47, 49.) Thus, the services rendered by chiropractors, naturopaths, and other categories of duly licensed medical providers have been excluded from coverage in foundation-approved plans.

It is undisputed that the foundation members who have agreed to accept the amounts set in the foundation fee schedules as "full satisfaction" of their bills to patients insured under foundation-approved plans have been the *very same persons* who have decided by majority vote what those amounts would be.

Defendants have repeatedly indicated both to their member doctors and to the various specialty groups of doctors in Arizona that the fees set by their uniform fee schedules have been intended to approximate the usual and customary charges of the majority of doctors in their communities. (Statement of Facts Nos. 42, 63.) Defendants have repeatedly asked other associations of doctors to meet and agree on the fees and fee schedules to be used by their members and to report the results of their agreements to

the defendants. (Statement of Facts Nos. 60, 62.) After their adoption by majority vote of the foundation membership, the defendants' fee increases have been circulated to doctors throughout the State of Arizona. (Statement of Facts No. 65.)

This Court has already found that the fee schedules adopted by the doctor members of the defendant foundations have set the maximum fees to be paid to doctors by insurers for services rendered to patients enrolled in health insurance plans approved by the foundations. (Memorandum and Order of June 5, 1979, at 2, 6. See Statement of Facts No. 48.) Indeed, the minimum standards promulgated by the defendent foundations have required the insurers which underwrite foundation-approved plans to pay 100 percent of the fees charged by doctors for services covered under those plans up to the maximum amounts set in the foundation fee schedule.[6] (Statement of Facts Nos. 43 & 46.)

The insurers which underwrite foundation plans have had no vote at all on the fee schedules which determine the amounts they are required to pay for doctors' services under foundation-approved plans. As this Court noted in its Memorandum and Opinion of June 5, 1976, at 6-7, this is not a situation in which insurance companies have individually determined the maximum prices to be paid and the physicians have individually agreed to those terms. To the contrary, this is a situation in which defendants admit that

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[6] This requirement binds the insurer with respect to non-participating as well as participating doctors. In the case of a participating doctor, however, the patient's claim is automatically assigned and paid directly to the doctor and the doctor agrees not to bill the patient for payment in excess of the amount set by the foundation fee schedule. In either case, the patient may be required to pay a fixed deductible amount. (*See* Statement of Facts No. 70, 48).

they have decided by majority vote of their members what prices they will accept for their services, and insurers and other third party payors have been required to pay those prices.

C. The Conduct at Issue

What is at issue in this lawsuit is the determination of prices to be paid for doctors' services by majority vote of an association of doctors rather than the independent business judgment of individual doctors and insurers. The anticompetitive character of the foundation fee schedules is well-illustrated by the procedures which the defendants have admittedly followed in adopting and maintaining them.

It is undisputed that the defendant foundations have repeatedly polled the various specialty groups of doctors in Arizona on the prices charged and the relative value schedules and conversion factors used or preferred by their members. (Statement of Facts Nos. 57-59, 61.) On some occasions, the foundations have explicitly asked specialty groups of doctors to poll their members concerning the unit values and conversion factors they should use in the future. (Statement of Facts No. 64.) In response to those requests by defendants, numerous price communications and price agreements have occurred involving many doctors who were not even members of the defendant foundations. (Statement of Facts Nos. 57, 59, 61, 64.) For example, on April 14, 1977, the Maricopa Foundation's President wrote to the presidents and secretaries of at least fifteen different specialty societies, stating in part:

> The Maricopa Foundation for Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area.

> To that end we would ask you to review with members of your specialty groups the present Foundation conversion factors (attached) and advise as to any changes you feel would be appropriate either on an overall conversion factor change or specific procedures where your group feels the payments are inequitable.
>
> We hope by these means to keep the Foundation concept viable in this community in protecting the private practice, free choice of physician method of health care delivery. (Exhibits MF-27 through MF-46 to Plaintiff's First Request for Admissions.)

Within a matter of weeks after that April 23, 1977 letter was sent to the specialty societies in Maricopa County, a number of those societies reported to the foundation that they had discussed and agreed upon the prices to be charged and the fee schedules to be used by their members. (*See* Exhibits MF-4 through MF-26 to Plaintiff's First Request for Admissions.) On the other hand, the representatives of several specialty groups notified the foundation that they would not participate in the foundation's price survey because it appeared to violate the antitrust laws. (Exhibits MF-20 through MF-22 to Plaintiff's First Request for Admissions.)

The defendants have also involved the specialty societies on a regular basis in their continuing efforts to revise, update and maintain the relative value schedules and conversion factors adopted by the foundation members. (Statement Facts No. 64.) On several occasions when new categories of doctors' services have been added to the coverage required by the foundations' minimum standards, the foundation fee schedules and payment criteria for those services have been prepared by associations of doctors who specialize in those fields of medicine. For example, in 1976 defendant Pima Foundation consulted the local pediatric society concerning the coverage and fees which the Pima Foundation should establish in its minimum standards for pediatric services. It was thereafter reported to the foundation that the society's members had "agreed to bill under

the 1964 California RVS 9040 with a factor of 11, which equals $14.40 with a Well-Baby Check office visit." (*See* Exhibit PF-109 to Plaintiff's First Request for Admissions.)

On repeated occasions defendant Maricopa Foundation has polled its member doctors for a "consensus" on prices and on the relative value schedules and conversion factors they used or desired to use. (Statement of Facts Nos. 50, 59, 63.) On such occasions, the membership has been informed that the foundation fee schedule should be "as close as possible" to the usual and customary fees charged by most doctors in the community. (Statement of Facts Nos. 42, 63.) On the heels of those price surveys, the foundation members have received proposed fee schedules recommended by the foundation's trustees with mail ballots for approval or disapproval of the proposed fee increases. (Statement of Facts Nos. 38-40.)

Typical of the Maricopa Foundations' membership polls is a June 7, 1977 letter to the foundation's members stating in part:

> [W]e feel it is time to survey the entire Foundation membership for their opinons concerning our fee schedule. While we do not feel that the Foundation Fee Schedule can be considered usual and customary for this area *we do feel strongly that it should approximate the majority of physicians charges."*

In order to arrive at a reasonable consensus we need your prompt response to the enclosed post card questionnaire.[7] *As soon as we tabulate this poll you will receive a ballot asking for your approval of any changes in the Foundation Fee Schedule.* (Exhibit MF-3 to Plaintiff's First Request for Admissions.)

In order to determine the allowable price set in a foundation fee schedule for a particular doctor's service, the user must refer to an agreed-upon relative value schedule and an agreed-upon unit conversion factor. (Statement of Facts No. 49.) Relative value schedules are lists or compilations of doctors' services which assign a comparative unit value to each service listed. (Statement of Facts No. 52.) Unit conversion factors are number or dollar figures used to multiply the unit value found in a relative value schedule for any doctor's service into a dollar figure payable for that service. (*See* Statement of Facts No. 53.) The foundation fee schedules provide unit conversion factors for six categories of medicine to be used with certain agreed-upon relative value schedules. (Statement of Facts No. 54.)

The defendant foundations have admittedly adopted, revised, published, circulated and encouraged the agreed-upon use by doctors of relative value schedules which were initially prepared and published by the California Medical

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[7] The post card questionnaire referred to in the letter was the following (Exhibit MF-2 to Plaintiff's First Request for Admissions (Emphasis added).):

Maricopa Foundation for Medical Care-1977 Fee Schedule

Write a single dollar conversion factor in your practice category.

Medicine_____ Surgery_____ Clinical Lab_____

Radiology_____ Anesthesiology_____

Please indicate the Relative Value Guide you are presently using.

	1964	1969	1974
California Relative Value Schedule	___	___	___

*Other (specify)*_____

Your speciality or field of practice_____
please print

Your name_____
please print

Association, The American College of Radiology and the American Society of Anesthesiology. (Statement of Facts No. 50.) In recent years, both the California Medical Association and the American College of Radiology have been enjoined by consent orders entered in proceedings before the Federal Trade Commission from preparing, revising, publishing or circulating the same relative value schedules which the defendants are continuing to update and revise in concert with their doctor members and other groups of doctors.* (Statement of Facts No. 51.)

Defendants have frequently adjusted the maximum prices payable for certain procedures by changing the unit values assigned to those procedures. (Statement of Facts No. 58.) For example, the maximum allowable price set by defendant Maricopa Foundation for a routine office visit was increased by 50 percent when the Maricopa Foundation increased the unit value accorded to such a visit from 1.0 to 1.5. On numerous occasions when defendants have adjusted the unit values for certain procedures in their adopted relative value schedules, they have acted in concert with groups of doctors who specialize in the procedures in question. (Statement of Facts Nos. 57-62. 64.)

While an increase in the relative value assigned to a specific procedure has only increased the maximum price for that procedure, an agreed-upon increase in the foundation conversion factor for any category of medicine has had the effect of increasing the prices allowed for all the doctors' services included in that medical category. (Statement of Facts No. 55.) Consequently, the information needed for a collective price increase for thousands of doctors' services has been provided to the foundation's doctor members on

* Consent decrees enjoining the agreed-upon use of relative value schedules by doctors have also been entered in a number of cases to date. *See, e.g.*, Reply Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability, at 10-11.

postcard ballots. On repeated occasions, the foundation's doctor members have voted by overwhelming margins to raise the price levels determined by the foundation conversion factors. (Statement of Facts Nos. 39-40.)

After their adoption, the foundation fee schedules have been published and circulated to doctors throughout the State of Arizona, including both members and nonmembers of the defendant foundations. (Statement of Facts Nos. 37, 65, 66, 67.) They have been mailed to foundation members, published in the monthly publications of both defendant societies, and mailed with applications for foundation membership to doctors who were not foundation members. (Statement of Facts Nos. 66, 68.)

The foundations have provided advance notice of their price increases to the insurers which underwrite foundation-approved plans, (Statement of Facts No. 74), and it is undisputed that the agreed-upon increases in defendants' fee schedules have resulted in increases in the premiums charged on those plans. (Statement of Facts Nos. 75.)

On several occasions, the increased conversion factors adopted by the Maricopa Foundation's membership have been sent to the Pima Foundation's Board of Trustees, and that Board has sent the same conversion factors to the Pima Foundation's membership for approval. (Statement of Facts Nos. 72.)

The record also establishes that foundation conversion factors have been increased to levels which were significantly higher than the average and median conversion factors charged by most doctors in Arizona at the time that the increase was approved. For example, the record clearly shows that in October of 1975 the trustees of defendant Maricopa Foundation recommended an increase in that foundation's conversion factors to a level that was substantially higher than the average charges of physicians statewide as shown in the results of a statewide price survey

conducted by the Arizona Medical Association and reviewed by the foundation's trustees immediately before they voted to recommend the foundation fee increase. (Statement of Facts Nos. 71.)

D. Effects of the Conduct at Issue

The agreed-upon relative value schedules and conversion factors adopted by the defendant foundations have clearly provided a comprehensive pricing system for doctors who practice on a fee-for-service basis in Arizona. It is undisputed that the periodic adoption of those comprehensive fee schedules has been the occasion for widespread meetings, discussions and agreements among doctors who sell the same services in the same community on a fee-for-service basis concerning the prices to be paid for those services and the relative value schedules and conversion factors which the doctors will use in determining those prices. By increasing their agreed-upon conversion factors from time to time, the members of the defendant foundations have agreed on overall increases in the prices set by the foundation fee schedule. (Statement of Facts No. 55.) On other occasions, defendants have increased the prices payable for certain procedures by increasing the unit values for those procedures; those specific price increases have not required a ballot of the foundation membership but have been published to all foundation members as well as to the insurers who must pay the increased prices. While the members of the California Medical Association and the American College of Radiology (including the members of the Arizona Radiological Society) have been enjoined from preparing, revising, publishing, or circulating their relative value schedules, the defendant foundations are performing those functions in their place here in Arizona.

Manifestly, the fee schedules adopted by foundation members provide the same maximum fees to be paid to all doctors regardless of their experience, training, expertise or reputation. It is also clear that the foundations' uniform fee schedules have led to uniform pricing, for the Maricopa

Foundation, which processes the doctors' bills, has admitted that 85 to 95 percent of foundation members bill at or above the rates set in the foundation fee schedules. This admission of uniform pricing is corroborated by the fee data collected by the Arizona Medical Association and the Health Insurance Association of America during 1975 and 1976, showing that the average fees charged by Arizona doctors over the level set in the fee schedules adopted by the foundation members. (Statement of Facts No. 71.) That data further indicates that after an increase in the level of fees set in the foundation fee schedule has been adopted by the foundation members, overall doctors' fees have risen to that level. (Statement of Facts No. 72.) It is undisputed that increases in doctors' prices result in increases in premiums for insurance plans which cover doctors' services. (Statement of Facts Nos. 75-76.)

It is also clear that reimbursement schedules for doctors can be determined by thrid party payors rather than doctors. Blue Cross and Blue Shield of Arizona, for example, provides doctors' services to its insured through a panel of doctors who decide individually whether or not to accept the reimbursement formula set by Blue Cross and Blue Shield. (See Exhibits A and B to the Alice McLain Affidavit; dated July 5, 1979, *Group Life & Health Insurance Co. v. Royal Drug Co.*, 995 S.Ct. 1067, 1072 (1979).

That the defendant foundations can provide administrative and peer review services to insurers without setting the fees which the insurers must pay to doctors has been proven by the defendants' own commercial experience. In a bid which defendant Maricopa Foundation recently submitted to the Arizona Department of Economic Security (Exhibit E-3 to Alice McLain Affidavit, Dated July 5) the foundation reported that it had successfully provided administrative and peer review services for the State of Arizona's Comprehensive Medical and Dental Program for Foster Children and sought to continue providing those services. Under Arizona law, maximum fees paid to doctors

under The Foster Children Program must be determined independently by the Department of Economic Security. (Exhibit C-1 to McLain Affidavit, ; Ariz. Rev. Stat. Ann. § 8-512(C). Accordingly, the Department has itself established a schedule of maximum fees payable for doctors' services under its Foster Children Program (Ariz. Rev. Stat. Ann. § 8-512(c)). Without setting the fees to be paid to doctors, therefore, the Maricopa Foundation has provided administrative and peer services for The Foster Children Program, with non-member and member doctors alike participating in the peer review function.

III.
DEFENDANTS' PRICE-FIXING IS UNLAWFUL UNDER RULE OF REASON ANALYSIS

A. The Conduct At Issue In This Case Has Been Anticompetitive In Purpose and Effect.

In *National Society of Professional Engineers v. United States*, 435 U.S. 679, 98 S.Ct. 1355 (1978), the Supreme Court reviewed "the contours of the Rule of Reason"* and discussed the application of that rule to a professional society's ethical rule against competitive bidding by its members. 435 U.S. at 687, 98 S.Ct. at 1363.

> The Court made it clear that contrary to its name, the Rule does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions. 435 U.S. at 688, 98 S.Ct. at 1363.

In *Professional Engineers*, the Supreme Court ruled that "an agreement that 'interfere[s] with the setting of price by free market forces' is illegal on its face." 435 U.S. at 692, 98 S.Ct. at 1365 (citation omitted). Even though the ban on competitive bidding at issue in *Professional Engineers* did

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* The development of the standard of reasonableness under the Sherman Act is more fully discussed in plaintiff's concurrent motion for reconsideration of the Memorandum and Opinion of June 5, 1979.

not in the Court's judgment constitute "price-fixing as such," the Court nevertheless held that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement" 435 U.S. at 692, 98 S.Ct. at 1365.

> It operates as an absolute ban on competitive bidding, applying with equal force to both complicated and simple projects and to both inexperienced and sophisticated customers. As the District Court found, the ban 'impedes the ordinary give and take of the market place,' and substantially deprives the customer of 'the ability to utilize and compare prices in selecting engineering service.' On its face, this agreement restrains trade within the meaning of § 1 of the Sherman Act. 435 U.S. at 692-93, 98 S.Ct. at 1365-66. (citation omitted).

In this case, the record exposes undisputed horizontal price-fixing which has had a direct and substantial impact on competitive conditions in the market for fee-for-service medicine. In a medical marketplace where each fee-for-service physician possesses a significant degree of natural monopoly power, the defendants have enlisted a substantial percentage of those physicians in a doctors' cartel which has determined by majority vote of its membrs the professional fees to be paid by third parties for medical services. With their admitted objective being the promotion of the commercial interests of fee-for-service physicians, the defendant foundations have established, maintained and circulated uniform and comprehensive pricing systems for fee-for-service doctors. Their uniform fee schedules and fee increases have resulted in uniform pricing and have suppressed the individual pricing of medical services by fee-for-service doctors and third party payors. No elaborate analysis is needed to discern the anticompetitive impact of such conduct.

Because the conduct at issue here *does* constitute "price-fixing as such,"[10] its anticompetitive character is even plainer than that of a ban on competitive bidding. In *Professional Engineers*, the Court was presented with "an agreement among competitors to refuse to discuss prices with potential customers until after negotiations [had] resulted in the initial selection of an engineer." 435 U.S. at 692, 98 S.Ct. at 1365. In this case, the Court is presented with an agreement among competitors not to discuss prices at all with third party payors, but rather to set by agreement among themselves schedules of uniform prices which they will accept from those third party payors. The record clearly demonstrates the anticompetitive character of those horizontal price agreements.

1. Defendants' Market Power Is Significantly Greater Than That of Ordinary Trade Associations.

The market power of the defendant foundations, whose membership comprises a substantial percentage of the fee-for-service doctors in Maricopa and Pima Counties, is far greater than that of an ordinary trade association. It has been widely recognized that "[e]ach fee-for-service doctor has a substantial amount of monopoly power over his individual patients as a result of their medical ignorance and dependency and their willingness to pay." Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 Law and Contemp. Prob. 716, 768 (1970) (Hereinafter "Havighurst, HMOs").

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[10] Plaintiff respectfully suggests that because the conduct at issue here constitutes "price-fixing as such," that conduct is more appropriately judged under the *per se* standard of analysis. This position is more fully briefed in plaintiff's motion for reconsideration of the Order of June 5, 1979, and will not be repeated in this memorandum. It must be noted however, that in *Professional Engineers* the Supreme Court expressly distinguished price-fixing from that conduct of a professional trade association which is appropriately analyzed under the Rule of Reason. 435 U.S. at 692, 98 S.Ct. at 1365.

> A physician possesses a degree of natural monopoly power over his patients and this power is enhanced by the presence of insurance which relieves patients of concern about fees or other costs. Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 660 (hereinafter "Kallstrom, *Fee Schedules*")

As explained in a recent law review article which was cited by this Court in its Memorandum and Order of June 5, 1979:

> The medical profession differs from many other trades because of the substantial market power, bordering on monopoly power, which every doctor and hospital wields in dealing with the consuming public. . . .
>
> Nevertheless, professional organizations in the health care sector resemble ordinary trade associations in that they represent and act to further the collective interests of the professions . . . It has been suggested that, in a subtle fashion, the very independence and power of their members makes these organizations even more dangerous than traditional trade associations because anticompetitive practices can be maintained within them with fewer formalities than is usually the case. Kallstrom, *Fee Schedules, supra* at 692, n. 197 (citations omitted).

It is therefore, no exaggeration to state that the defendant trade associations, whose membership comprises a substantial portion of the fee-for-service doctors in their communities, are in effect combinations of monopolists with unique power as sellers in the medical marketplace.

2. Defendants Have Cartelized the Pricing of Doctors' Services.

From their inception the defendant foundations have served the function of establishing and maintaining "uniform fee schedules" which were adopted and revised by majority vote of a substantial portion of the fee-for-service doctors in their communities.

By setting a cartel price for the services they provide to insured persons, the foundations' member doctors have directly restricted independent pricing of doctors' services and have curtailed the bargaining power which third party payors might have exercised in the absence of a doctors' cartel. Rather than negotiate with individual fee-for-service providers in Arizona on the prices to be paid for professional services, third party payors have been faced with a doctors' cartel that has already decided by a majority vote of its members what prices they will accept from third parties for medical services to insured patients.

In a recent article, Professor Havighurst aptly described the anticompetitive character of cartel pricing by foundations for medical care:

> Under the procompetitive premise of the antitrust laws, FMCs [foundations for medical care] and similar [professionally controlled health financing plans] should be recognized as part of a profit-maximizing strategy of a coalition of monopolists. Case law suggesting that the fixing of maximum prices is regarded no more favorably than minimum-price fixing would seem appropriately invoked to curb private price regulation undertaken by a cartel. In many market circumstances, an FMC could be challenged as an exclusionary tactic of a monopolist or as the product of a conspiracy to monopolize the provision of medical care. The most likely theory of attack on FMC-type efforts, however, would be under section 1 of the Sherman Act as a combination in restraint of trade lacking virtues sufficient to redeem its several anticompetitive features. The fundamental premise of the antitrust laws, which can be contested in a legislative but not in a judicial forum, is that the competitie solution is always preferable to the cartel's. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 377-378 (footnotes omitted) (hereinafter Havighurst, *Professional Restraints.*)

3. Defendants' Cartel Pricing Has Suppressed the Bargaining Power of Third Party Payors.

In determing by agreement what professional fees should be paid by insurance companies and other third party payors, the defendants and their doctor members have not only suppressed independent pricing by doctors, they have usurped an economic function which would otherwise have been performed by the party responsible for paying those fees. It is undisputed that the foundations' fee schedules and minimum standards have been formulated by defendants and their members in a completely horizontal combination. The insurance companies and other third parties that underwrite foundation-approved plans have had no vote whatsoever on the professional fees they must pay under those plans.

If it were not immediately obvious that the determination of professional fees to be paid by insurers through associations of doctors devoted to fee-for-service practice was inherently anticompetitive, the defendants' conduct has made their restrictive purpose clear. Under the minimum standards promulgated by the defendants, professional fees can only be paid to medical or osteopathic physicians and surgeons, podiatrists and dentists; the services of duly-licensed chiropractors, naturopaths and other medical practitioners have been excluded from coverage. Consequently, persons insured under foundation-approved plans have been limited in their choice of medical treatment to the categories of treatment in which the defendants' members engage, and the insurers' determination of the types of medical treatment to be covered has been made for them by a doctors' cartel.

Just recently the Supreme Court commented on the "serious anticompetitive consequences" which result from this type of physician control over the professional payments made by third party payors. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 99 S.Ct. 1067, 1083-84, n. 40 (1979). The Court warned that *exempting provider agree-*

ments from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Id. (emphasis added). Noting that "physicians and other health care providers typically dominate the Boards of Directors of Blue Shield plans," the Court surmised that as a result of such physician control *"there is little incentive . . . to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level." Id.* at 1083-84, n. 40 (emphasis added). This physician domination of insurers, the Court noted, was "said to have resulted in rapid escalation of health care costs to the detriment of consumers generally." *Id.* (citation omitted.)[11]

It is noteworthy that the members of the Supreme Court were unanimous in their concern over the anticompetitive impact of horizontal combinations in the health care industry. Even those Justices who dissented from the majority ruling in *Royal Drug* commented that a horizontal conspiracy of providers which pressured an insurer to go along with its arguments, would constitute an "illegal conspiracy" which was "neither necessary nor related to the insurer's effort to satisfy its obligations to its policyholders." *Id.* at 1094 (Brennan, J., dissenting).

Not only is the horizontal price fixing of the defendants unnecessary to the insurer's efforts to satisfy its policy obligations, it is a direct and severe restraint on the bargaining power of the insurer in negotiating reimbursement sched-

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[11] See Staff Report to the Federal trade Commission and Proposed Trade Regulation Rule, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans* (April 1979); CCH Trade Reg. Rep. No. 384, at 6 (May 7, 1979).

It should perhaps be noted that the one-time relationship between Blue Shield of Arizona and the Arizona Medical Association was severed several years ago. More recently, the Ohio State Medical Association agreed to sever its relationship from the Ohio Blue Shield Plan as a term of the consent judgment entered in *State of Ohio v. Ohio Medical Indemnity, Inc.*, 1976-2 CCH Trade Cas. ¶ 61,128 (S.D. Ohio, filed September 16, 1976) (copy of consent judgment attached as Exhibit F to Statement of Facts.)

ules with fee-for-service physicians. A recent decision of the Court of Appeals for the District of Columbia Circuit held that a similar restraint on the bargaining power of sellers in professional sports was unlawful under Rule of Reason analysis. *Smith v. Pro Football Inc.*, 593 F.2d 1173 (D.C. Cir. 1978), held that the player selection system of "draft" of the National Football League ("NFL") was a violation of section 1 of the Sherman Act under the Rule of Reason because it deprived football players of their "real bargaining power" in negotiating with NFL teams. Noting that there were less anticompetitive alternatives to the draft system the court held that "this level of restraint cannot be justified." 593 F.2d at 1187. For similar reasons, the Court of Appeals for the Eighth Circuit has held that the NFL's Rozelle Rule is unlawful. *Mackey v. National Football League*, 543 F.2d 606, 621-622 (8th Cir. 1976), and the Federal District Court for the Northern District of California has held the NFL's Rozelle Rule, player draft rule, one-man rule, tampering rule and Standard Player Contract rule unlawful under Rule of Reason analysis. *Kapp v. National Football League*, 390 F. Supp. at 82. Although those cases did not involve the severe anticompetitive impact of a direct restraint on price, the restriction of the bargaining power of football players under NFL rules was deemed an impermissible restraint upon the market for players' services.

4. Defendants' Challenged Practices Have Had a Direct and Substantial Impact on Prices.

A primary function of the defendant foundations since their inception has been the preparation and adoption of "uniform fee schedules" for doctors' services. So basic is price fixing to the function of those trade associations that the principal incident of membership in the foundations has been the power to vote on "uniform fee schedules." Indeed, the very By-Laws of the defendant foundations expressly provided for the establishment of standing fee schedule committees and specifically authorized the foun-

dations' trustees to prepare and recommend changes in the foundation fee schedules which could only be adopted by mail ballots of the foundations' member doctors. The procedures by which the defendants have maintained and revised those fee schedules through widespread price surveys and price agreements among the foundations' member doctors and the various specialty groups of doctors in Arizona have clearly been intended to result in agreed-upon price levels for doctors.

Examination of the business records of the defendants reveals that defendants have consistently strived to keep their "uniform fee schedules" at a level approximating "the majority of physicians' charges" and have so advised their members. The repeated polls, meetings, discussions and agreements among doctors which the defendants have instigated regarding the prices to be charged and the relative value schedules and conversion factors to be used by doctors have involved future as well as current pricing information, and have included both members and nonmembers of the foundations. Defendants have made it clear that the fee schedules they have proposed to their members for adoption represented a consensus on the prices which doctors in the community would be charging in the period after the fee schedules were adopted, and it is established that over 85 percent of the foundations' member doctors have billed their fees at or above the levels set in those fee schedules. Thus, the record clearly shows that the defendants' fee schedules were intended to function and did function as uniform fee schedules for foundation members.

It is particularly significant that both the preliminary price agreements encouraged by the defendants and the adoption of fee schedules by majority vote of the defendants' doctor members were manifestly intended to result in collective price increases. Even if the prices charged by doctors had not been uniform at the time a new fee schedule was adopted, the agreement of defendants' doctor members to raise their prices simultaneously operated as a

direct restraint on independent pricing decisions. In this case, the anticompetitive character of an agreement to raise prices at a given time was exacerbated by the defendants' widespread communications that the proposed price increases represented a "consensus" and would approximate the charges of most doctors in the community.

Through defendants' publication of the agreed-upon increases in the fees set by the foundation fee schedules, doctors who might not have considered their current prices too low have been reminded that the majority of the foundations' doctor members consider the newly increased fee schedule to be appropriate. If there could be any doubt that the defendants' repeated communications of price increases and price agreements have had a substantial anticompetitive impact, the admitted fact that 85 to 95 percent of foundation members bill at or above the level of fees set by the foundation fee schedule would surely resolve it.

It is undisputed that increases in the doctors' fees set in the foundation fee schedule result in increases in the premiums charged on foundation-approved health plans, and that general increases in doctors' prices result in general increases in health insurance premiums. Since the admitted facts in this case establish that 85 to 95 percent of the doctor members of the foundation bill at or above the level of fees set by the foundation fee schedule and the foundation membership includes a large percentage of the fee-for-service doctors in Maricopa and Pima Counties, it follows *a fortiori* that increases in the level of fees set by the foundation fee schedule have resulted in general fee increases for many doctors in those counties, and those fee increases have in turn resulted in increases insurance premiums.

There is no dispute that the agreed-upon relative value schedules and conversion factors adopted by the foundations' doctor members provide a comprehensive pricing system for fee-for service doctors. The establishment and maintenance of a uniform pricing system is by itself a substantial anticompetitive result of the defendants' activities.

In the absence of an agreed-upon pricing system, individual doctors might develop their own pricing methods and bargain individually with third party payors on the prices they would accept for their services. By producing and publishing a consensus on appropriate fees and fee schedules, the defendants have suppressed the diversity of doctors pricing which might otherwise prevail.

Indeed, the setting of uniform prices for all doctors' services irrespective of the training, experience, reputation and expertise of the individual doctor is a significant restraint in itself. A third party payor might well tend to offer a lower price to a novice doctor than to a renowned specialist, but the foundations dictate that all be paid the same. In the analogous area of legal fees, one would naturally balk at being asked to pay to an associate fresh out of law school the same hourly fee that an experienced, highly-reputed attorney would command. *See, e.g.*, Opinion and Order of April 16, 1979 in *In re Arizona Dairy Products Litigation*, No. CIV 74-569 A PHX CAM (D. Ariz., filed [date of complaint]), at 3-4 (finding that rates ranging from $60.00 per hour for a new associate in his/her first year out of law school up to $90.00 for an attorney not yet four years out of law school were excessive in the circumstances of that case, Judge Muecke reduced certain attorneys' fees to "what the Court feels are reasonable rates of compensation for persons of comparable skill and experience in the Phoenix area.") Like an attorney's hourly rate, a doctor's conversion factor might be set in accordance with the individual doc-

tor's experience and training were it not for the uniform pricing established by the defendants.[18]

The anticompetitive impact of uniform pricing by professionals was recognized and condemned by the district court in *Goldfarb v. Virginia State Bar*, 355 F. Supp. 491 (E.D. Va. 1973). Noting the impact which agreed-upon fee schedules necessarily have on entry pricing by new members of a profession, the court held such fee schedules "to be repugnant to the philosophy of the Sherman Act."

> This type of price-fixing has been held under other circumstances to be repugnant to the philosophy of the Sherman Act. *Plymouth Dealers Ass'n v. United States*, 279 F.2d 128 (9th Cir. 1960). It is contrary to the spirit of competition which sustains a free enterprise system in that it prevents competitors from using their own judgment in determining the value of their own services. *Keifer-Stewart Co. v. Seagram and Sons*, 340 U.S. 211, 213 (1951).

The district court explained the impact of fee schedules on consumers:

> There is no distinction between the benefits ascribed to the minimum fee schedule by its advocates and those existing in a minimum sales price if, for example, the latter were to be adopted by General Motors and Ford Motor Company as to suggested sales prices for comparable automobiles. In each instance, a new dealer and a new lawyer, both unfamiliar with the customary charges in the field, would find such a

[18] In fact, many insurers do adjust their allowable payments for doctors' services in accordance with the "usual fees" of the individual provider. (*See, e.g.*, Exhibits to McLain Affidavit describing the payment criteria of Blue Cross and Blue Shield of Arizona.) While the "UCR" reimbursement method has been criticized as inflationary, it is relevant here to note that many insurers have, in the exercise of their independent business judgment, chosen *not* to use a reimbursement schedule which provides uniform payments to all doctors, but the pricing uniformity encouraged by the defendants' horizontal price agreements suppresses the individual development of varying "usual fees" by doctors.

> minimum fee or sales price schedule helpful in setting charges. In each instance an adequate fee or price would insure a margin of profit adequate to assure further research and development or continued legal education. In each instance the public would be assured, by an examination of such schedule, that what was being charged was in line with what was generally charged in the field. Yet in none of these instances would a member of the public have any better idea that the fee or price was reasonable after he had seen the schedule than he did before. *Id.*

The conclusion of the district court that the professional fee schedules violated the Sherman Act was, of course, confirmed by the Supreme Court. 421 U.S. 773, 95 S.Ct. 2004 (1975).

More recently, another district court reviewed the coordination and publication of rate schedules by a rate bureau for common carriers. *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471 (N.D. Ga. 1979). Like the defendants in this case, the rate bureau had prepared, proposed, published and circulated rate schedules, which the district court held to be a "naked price restraint" which violated the Sherman Act "at its most sensitive spot." 467 F. Supp. at 486. Holding that the horizontal coordination of rates was unlawful under both *per se* analysis and the Rule of Reason, the court granted plaintiff's motion for summary judgment and injunctive relief. *Id.* at 486-87.

The evidence in this case corroborates what the long line of cases dealing with horizontal price fixing has taught:

> The aim and result of every price-fixing agreement . . . is the elimination of one form of competition. *United States v. Gillen*, 1979-1 CCH Trade Cas. ¶ 62,627 at 77,579 (3d Cir. 1979), quoting *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1926).

Because defendants' challenged practices have had a direct and substantial impact on the pricing of individual doctors' services, it is outside the pole of the Sherman Act under the Rule of Reason.

B. This Level Of Price Restraint Is Patently Unreasonable.

As this Court recognized in its Memorandum and Order of June 5, 1979, it is of no consequence that the foundations' member doctors technically remain free to charge whatever price they wish, as they have agreed in advance to accept the amount determined by the foundation fee schedule in full consideration for their services. Slip Op. at 6. By defining the level of fees which doctors will accept from third party payors, the defendants have directly impinged "the freedom of [individual doctors and insurers] and thereby restrain[ed] their ability to sell in accordance with their own judgment." *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211, 213, 71 S.Ct. 259, 260 (1951). When competitors agree on a "starting point" or "range" of prices fro the services or products they sell, an essential form of competition is eliminated regardless of whether the agreed-upon prices are maximum or minimum, uniform or list prices and whether the agreement is mandatory or voluntary.

> Common sense tells us that there is no need for competitors to meet, agree upon content, print and circulate 'list prices' that are never to be looked at. *Plymouth Dealers' Ass'n of Northern California v. United States*, 279 F.2d 128, 133 (9th Cir. 1960). *See also Vandervelde v. Put and Call Brokers and Dealers' Ass'n*, 334 F. Supp. 118, 134 (S.D.N.Y. 1972).

Although horizontal price restraints are universally judged under the *per se* rule, several courts have held in the alternative that price agreements which were strikingly similar to those at issue in this case were also unlawful under Rule of Reason analysis. For example, *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah

1962), *aff'd*, 371 U.S. 24, 83 S.Ct. 119 (1962), involved an association of independent pharmacists which adopted a pricing schedule and successive revisions, distributed them to members throughout the State of Utah and encouraged the members to use the schedule for the pricing of prescription drugs. 201 F. Supp. at 34. Finding that "one cannot lawfully agree with others to fix the price of goods in commerce merely because of professional credentials or because such price-fixing also touches upon professional fees," the district court held that the association's price schedules were *per se* illegal. 201 F. Supp. at 35, *citing United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 60 S.Ct. 811 (1940), and *United States v. Trenton Potteries Co.*, 273 U.S. 392, 47 S.Ct. 377 (1947). Alternatively, however, the court held that the association's price schedules were also unlawful under Rule of Reason analysis.

> *There could not be considered reasonable under any circumstances a conspiratorial agreement, and the distribution and promotion of implementing price schedules, among those in a dominant position in the business and profession of dispensing drugs within the State of Utah, which carried to the extent sought by the Association would almost completely remove price competition in the field of prescription drugs.* The good faith and professional standing of those concerned being fully accepted, if such a system were accepted as reasonable, any other similar group of well intentioned men could accomplish the same results in their own businesses through their own associations. This result, with any effective agreement to that end, is unacceptable to the antitrust laws. It is the duty of a Court to apply these laws in easy cases as well as hard cases, and as against well intentioned parties to an agreement conspiratorial only in law as well as against conspirators in sinister sense which, of course, cannot apply to the parties before the Court. Even under the 'rule of reason,' as said in *Board of Trade of City of Chicago v. United States, supra*, 'The true test of legality is whether the restraint imposed is such as

> merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.' The system promoted by the Association does not meet this test[.]
> 201 F. Supp. at 35-36.

Accord, Northern California Pharmaceutical Ass'n v. United States, 306 F.2d 379 (9th Cir.), *cert. denied*, 371 U.S. 262, 83 S.Ct. 119 (1962) (holding almost identical facts sufficient for criminal liability under section 1 of the Sherman Act.) 306 F.2d at 391. The extensive analysis of the Ninth Circuit in *Plymouth Dealers Ass'n, supra*, and of the District Court for the Southern District of New York in *Vandervelde v. Put and Call Brokers and Dealers' Ass'n, supra*, would also support a holding of illegality on a Rule of Reason standard, though the price fixing at issue in those cases was held to be unlawful *per se*. As the district court noted in *United States v. Southern Motor Carriers Rate Conference*, 467 F. Supp. at 486-87, n. 11, the focus of inquiry in a price fixing case under the Rule of Reason continues to be on the effect of the challenged conduct on price competition.

> The essence of the antitrust laws is to ensure fair price competition in an open market. *Reiter v. Sonotone Corp.*, 47 U.S.L.W. 4672, 4675 (Sup. Ct., June 11, 1979).

Because the conduct at issue in this case operates as a direct restraint on "the setting of price by free market forces," it is "illegal on its face" under the Rule of Reason. *National Society of Professional Engineers v. United States*, 435 U.S. at 692, 98 S.Ct. at 1365.

C. The Conduct At Issue In This Case Is Far More Restrictive Than Necessary For Any Legitimate Aims The Defendants Might Assert.

If the defendants' objective were simply to establish a panel of fee-for-service doctors to provide doctors' services to patients covered under certain types of health insurance,

there would be no need for the professional fees paid by insurers to be determined by a doctors' cartel. Insurers and other third parties are fully capable of devising a reimbursement schedule for doctors' services and organizing a panel of fee-for-service doctors who would decide individually to accept that reimbursement schedule. *Professional Restraints, supra,* at 326-334; Kallstrom, *Third Party Payors, supra,* at 660 (insurer initiated fee schedules are a means of lowering health care costs by counteracting the monoply power of physicians; *see* Exhibits to McLain Affidavit.)

Were it defendants' purpose to contain the price of fee-for-service medicine, that could be accomplished far more effectively by the foundations' doctor members charging lower prices to all patients than by their repeated cycles of surveys, meetings and agreements on price increases and uniform fee schedules. Indeed, courts and commentators alike have recognized that the control of insurance reimbursement schedules by doctors' associations has had an inflationary, not a deflationary, effect on doctors' prices. *E.g., Group Life and Health Insurance Co. v. Royal Drug Co.,* 99 S.Ct. at 1083-84, n. 40; Havighurst, *Professional Restraints, supra* at 377 (FMCs should be recognized as part of a profit-maximizing strategy of a coalition of monopolists). Under these circumstances the control which the defendant foundations and their voting members have exer-

cised over the professional fees paid by third parties merits searching scrutiny.[13]

As one commentator cited in this Court's recent Memorandum and Opinion of June 5, 1979 has concluded,

> Fee schedules that are developed with any involvement by a medical association of any kind should be condemned per se. Fee schedules that are initiated as the independent effort of insurers, however, and are negotiated with doctors who make their decisions individually, should be encouraged. This kind of arrangement should be approved unless there is affirmative proof that it has been abused—that it is a sham that hides an agreement among doctors, perpetrated either by a deliberate combination to fix prices or through the more subtle pressures of a medical association . . . .
>
> *Perhaps the most blatant examples of concerted provider involvement in fee setting arrangements are the FMCs* (Foundations for Medical Care). Kallstrom, *Third Party Payors, supra* at 680.

The Maricopa Foundation has already demonstrated that the defendant foundations can provide administrative and peer review services to a health care program without also

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[13] A recent Staff Report to the Federal Trade Commission concludes that medical participation in the control of many medical financing plans has resulted in a situation where "the price paid for physicians' services responds to the will of the medical profession and the 'house of medicine' decides whether and how much the plans will pay for the services of non-physicians," and recommends that the Commission commence a rule-making proceeding and approve a proposed rule providing that "it is an unfair method of competition for any physician organization directly or indirectly to control or to participate in controlling any open-panel medical care prepayment plan." Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans*, 1-2, 32 (April 1979), 913 BNA Antitrust Trade Reg. Rep. E-1 (May 10, 1979).

determining the prices paid to doctors under that program. Although under Arizona law the reimbursement schedule for the States Comprehensive Medical and Dental Program for Foster Children must be determined on an independent basis by the Arizona Department of Economic Security, the Maricopa Foundation has been able to perform both administrative and peer review services for that program. (Exhibit 1 to McLain Affidavit: Ariz. Rev Stat. Ann. § 8-512(c)). Thus, the price-fixing activities at issue in this case are *not* necessary to the peer review and administrative services performed by the defendant foundations.

Because the price-fixing activities of the defendant foundations have been far more restrictive than necessary to achieve any legitimate end of the defendant associations, those activities should be held unlawful restraints of trade under the Rule of Reason analysis adopted by this Court. *Smith v. Pro Football, Inc.*, 593 F.2d at 1183-89; *Mackey v. National Football League*, 543 F.2d at 621-22; *Kapp v. National Football League*, 390 F. Supp. at 82-83.

IV

PLAINTIFF IS ENTITLED TO SUMMARY JUDGMENT UNDER THE RULE OF REASON

The material facts which establish the anticompetitive purpose and effect of the price-fixing activities challenged in this lawsuit are not in dispute. Because those price surveys, meetings and agreements on uniform fee schedules and fee increases are patently unreasonable on their face and are far more restrictive than necessary for any legitimate purpose of the defendant foundations, there is no genuine issue for trial. *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. at 486-87; *Kapp v. National Football League*, 390 F. Supp. at 82. *See National Society of Professional Engineers v. United States* 435 U.S. 679, 98 S.Ct. at 1362-68 (affirming lower

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court decision based on *per se* analysis and holding it was not error for district court not to make finding on defendant's assertion that competition would lead to inferior engineering work).

> Summary judgment for violations of the antitrust laws is proper where less restrictive means than those used could have been employed. *International Salt Co. v. United States*, 332 U.S. 392, 397-398, 68 S.Ct. 12 (1947)

In *Associated Press v. United States*, 326 U.S. 1, 65 S.Ct. 1416 (1945), the Supreme Court upheld a district court's order granting summary judgment and permanent injunctive relief for the government against enforcement of the Associated Press's restrictions on membership. *See* 52 F. Supp. 362. Engaging in a Rule of Reason analysis, the Supreme Court held the restraint at issue in that case to be unlawful and concluded that

> [T]here was no injury to any of the appellants as a result of summary proceedings since . . . the restrictive arrangements which appellants admitted, were sufficient to justify summary action by the court at that stage of the case. 326 U.S. at 6, 65 S.Ct. at 1418.

See also Silver v. New York Stock Exchange, 373 U.S. 341, 83 S.Ct. 1246 (1963).[14] Because the pleadings, depositions, admissions and affidavits on file in this matter show that there is no genuine issue as to any material fact, plaintiff is entitled to judgment under Rule 56(c), Federal Rules of Civil Procedure.

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[14] *Cf., Goldfarb v. Virginia State Bar*, 355 F. Supp. 491 (in bifurcated proceedings, issue of liability was determined on the basis of a one day hearing); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. at 30 (most of the material facts having been stipulated, trial of case required less than one day).

V

PLAINTIFF IS ENTITLED TO A PERMANENT INJUNCTION AGAINST DEFENDANTS' UNLAWFUL PRICE-FIXING ACTIVITIES

It is well-established that under section 16 of the Clayton Act, 15 U.S.C. § 26, injunctive relief is appropriate not only to avoid a recurrence of defendants' violations of the Sherman Act, but also to eliminate the anticompetitive consequences of defendants' conduct. *National Society of Professional Engineers v. United States*, 435 U.S. at 697, 98 S.Ct. at 1368; *International Salt Co. v. United States*, 332 U.S. 392, 400-401, 68 S.Ct. 12, 17 (1947); *United States v. Glaxo Groups, Ltd.*, 410 U.S. 52, 64, 93 S.Ct. 861, 868 (1973). Similarly, Arizona's Uniform State Antitrust Act provides for appropriate injunctive relief against violations of the Act. Ariz. Rev. Stat. Ann. § 44-1408. Having carried its burden of proving that defendants' conduct is in violation of the Sherman Act and the Uniform State Antitrust Act under both the Rule of Reason and the *per se* rule, plaintiff is entitled to permanent injunctive relief. *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. at 473, 487.

VI

IN THE ALTERNATIVE, THIS COURT SHOULD ENTER AN ORDER PURSUANT TO RULE 56(d), FEDERAL RULES OF CIVIL PROCEDURE, SPECIFYING THE ISSUES OF FACT AND LAW WHICH REMAIN TO BE TRIED IN THIS MATTER.

Should the Court not render summary judgment in plaintiff's favor, the preparation of this case for trial would be greatly assisted by the entry of an order pursuant to Rule 56(d), Federal Rules of Civil Procedure, specifying the facts that appear without substantial controversy and the issues of law and fact which remain to be tried. Plaintiff believes that, should its motions be denied, the motion for preliminary injunction which plaintiff filed in this matter on October 25, 1978 could be brought on for hearing within a

few weeks, and a trial on the merits held within a matter of months. There is, however, some uncertainty as to the issues of fact which would remain to be tried and the discovery which would be necessary for trial under a Rule of Reason standard. In the absence of summary judgment, an order specifying the issues of law and fact which remain to be tried at the order to show cause hearing and the trial on the merits and directing that the order to show cause hearing be held forthwith in accordance with Local Rule 42 would prevent unnecessary discovery and delay and expedite the resolution of the important issues raised by this lawsuit to the mutual benefit of all parties.

VII

CONCLUSION

WHEREFORE, plaintiff STATE OF ARIZONA respectfully requests that this Court enter its order:

1) granting plaintiff's motion for summary judgment and permanent injunction, or, alternatively,

2) specifying the facts that appear without substantial controversy and the issues of fact and law that remain to be tried and directing further proceedings in this matter including the hearing of plaintiff's motion for preliminary injunction.

DATED: July 6, 1979.

(signatures omitted in printing.)

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

STATEMENT OF UNDISPUTED FACTS SUPPORTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

Plaintiff STATE OF ARIZONA submits, pursuant to Rule 11(h), Rules of Practice of the United States District Court of the District of Arizona 1978, the following statement of undisputed material facts which support plaintiff's motion for summary judgment and permanent injunction. The following facts have been established by the business records and sworn testimony of the parties and certain witnesses, by Defendants' Responses to Plaintiff's First Request for Admissions and by public records. Defendants have stipulated that the documents which are attached as Exhibits to Plaintiff's First Request for Admissions are their business records. (Exhibit D to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References.)

STATEMENT OF FACTS

1. Each of the defendants is an association of doctors. (Maricopa County Medical Society's Response to Plaintiff's First Request for Admissions hereinafter "Maricopa Society's Admissions") No. 309; Maricopa Foundation for Medical Care's Response to Plaintiff's First Request for Admissions, (hereinafter "Maricopa Foundation's Admissions" Nos. 310-311; Pima Foundation for Medical Care's Response to Plaintiff's First Request for Admissions (hereinafter "Pima Foundation's Admissions") No. 428. Defendants Responses to Plaintiff's First Request for Ad-

missions are found in the record as Exhibits A, B and C to the Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability with Supplemental References.)

2. The defendant Societies have known and approved of the activities of the defendant foundations. (Maricopa Society's Admissions Nos. 198, 200-203, 222, 314; Exhibit MS-4 and MS-5 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 198-203, 222; Exhibits MF-52, MF-80, MF-119 to Plaintiff's First Request for Admission; Exhibits PF-134 and PF-139 to Plaintiff's First Request for Admission.)

3. The defendant societies founded the defendant foundations for the purpose of promoting the interests of fee-for-service medicine. (Maricopa Foundation's Admissions No. 91; Pima Foundation's Admissions No. 317; Exhibits MF-27, MF-79, MF-89, MF-90 and MF-95 to Plaintiff's First Request for Admissions.)

4. Defendants have repeatedly represented that their membership represents a substantial percentage of the fee-for-service physicians in their respective communities. (Maricopa Foundation Admissions Exhibit MS 1; Pima Foundation Admissions Exhibit PF-125; of Alice McClain dated July 5, 1979 attached as Exhibit C to this Statement).

5. The Board of Directors of defendant Maricopa County Medical Society (Hereinafter Maricopa Society) is elected by the membership of the Maricopa Society. (Maricopa Society's Admissions No. 2.)

6. The membership of defendant Maricopa Foundation for Medical Care hereinafter ("Maricopa Foundation") has included:

a. administrative members, who are the members of the Board of Directors of defendant Maricopa Society;

b. participating members, who belong or are qualified to belong to the Maricopa Society or any other county medical society in Arizona or the Arizona Osteopathic Society;

c. cooperating members who are members of the Arizona Podiatry Society or the Arizona Society of Oral Surgeons (Maricopa Foundation's Admissions No. 1. (Chapter II, Sections 1 through 7, By-Laws of Maricopa Foundation, Exhibit MF-122 to Maricopa Foundation's Admissions.)

7. The membership of defendant Maricopa Society is "limited to select physicians chosen by the Maricopa Society." (Maricopa County Medical Society's Articles of Incorporation, certified copy attached as Exhibit A to this Statement.)

8. The defendant societies are the local components of the Arizona Medical Association, which is in turn a component of the American Medical Association. (Articles of Incorporation of Arizona Medical Association certified copy attached as Exhibit A to this Statement).

9. The members of the Board of Directors of the defendant Maricopa Society automatically become administrative members of defendant Maricopa Foundation. (Maricopa Foundation's Admission No. 3.)

10. The administrative members of defendant Maricopa Foundation have elected by majority vote the Board of Trustees of the Maricopa Foundation. (Chapter XI, Section 1, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions; Maricopa Society's Admissions Nos. 5, 177, 245, 264, 267, 308; Maricopa Foundation's Admissions Nos. 177, 245, 264, 267, 308; Exhibits MS-1, MS-10 through MS-13 and MF-67 to Plaintiff's First

11. At least nine members of the Board of Trustees and all members of the Executive Committee of defendant Maricopa Foundation must be participating members of the Maricopa Foundation. (Chapter V, Section 2, and Chapter VI, Section 4, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

12. Among the powers of the Trustees of defendant Maricopa Foundation is the power "to adopt and to propose to the participating membership uniform average or median fee schedules for medical services, which when adopted by a majority vote of the participating membership shall be binding upon all participating members[.]" (Chapter V, Section 2, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

13. The voting power of participating and cooperating members of defendant Maricopa Foundation has been limited to the power "to vote on the adoption of any uniform average or median fee schedule for medical services by mail ballot." (Maricopa Foundation's Admissions No. 34, Exhibit MF 122 to Plaintiff's First Request for Admissions; Chapter II, Sections 5, 7, By-Laws of Maricopa Foundation.)

14. Applicants for participating membership in defendant Maricopa Foundation have been required to complete and sign an application blank which contains an agreement "to be bound by any and all rules, regulations, committee decisions, fee schedules, and the like, adopted by [the foundation]." (Chapter II, Section 9, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions.)

15. Defendant Maricopa Foundation has had a standing fee schedule committee. (Chapter X, Section 2, By-Laws of the Maricopa Foundation, Exhibit MF-122 to Plaintiffs First Request for Admissions.)

16. Defendant Pima County Medical hereinafter Pima Society Society severed its relationship with defendant Pima Foundation for Medical Care hereinafter ("Pima Foundation") in October, 1978, after the complaint in this action had been filed. (October, 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

17. The membership of defendant Pima Foundation from its inception until October, 1978 included:

a. administrative members, who were the members of the Board of Directors of defendant Pima Society;

b. participating members, who belonged or were qualified to belong to the Pima Society or the county medical society in a county contiguous to Pima County;

c. cooperating members, who were members of the Arizona Osteopathic Society or the Arizona Podiatry Society who practiced in Pima County.

(Chapter II, Section 1, By-Laws of Pima Foundation, Ehibit PF-188 to Plaintiff's First Request for Admissions.)

18. The administrative members of defendant Pima Foundation from its inception until October, 1978, were elected by majority vote of the Board of Directors of defendant Pima Society. (Chapter XI, Section 1, By-Laws of Pima Foundation, Exhibit PF 183 to Plaintiff's First Request for Admissions; Pima Foundation's Admissions No. 416; Exhibits PS-7 through PS-33 to Plaintiff's First Request for Admissions.)

19. Until October, 1978, two-thirds of the Trustees of defendant Pima Foundation were required to be participating or cooperating members of the Pima Foundation. (Chapter VI, Section 4, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

20. Among the powers of the Trustees of defendant Pima Foundation from its inception until October, 1978, was the power "to adopt and to propose to the Participating Membership uniform fee schedules for medical services, which when adopted by the majority vote of the Participating Membership [were] binding upon all Participating Members of [the Pima Foundation.]" (Chapter V, Section 2, By-Laws of Pima Foundation dated, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

21. From the inception of defendant Pima Foundation until October, 1978, the voting power of its participating members was limited to "the power to vote on the adoption of any uniform fee schedule for medical services by the Foundation . . . by mail ballot." (Chapter II, Section 5, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

22. Applicants for participating membership in defendant Pima Foundation from its inception until October, 1978, were required to complete and sign an application blank which contained an agreement "to be bound by any and all rules, regulations, committee decisions, fee schedules, and the like, adopted by [the Pima Foundation.]" (Chapter II, Section 9, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

23. Defendant Pima Foundation has had a standing fee schedule committee. (Chapter X, Section 2, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions.)

24. Since October, 1978, defendant Pima Foundation has had one class of Corporate Members which is open to "any physician or podiatrist authorized [under Arizona law] to practice medicine in the State of Arizona who practices in

Pima County or a county contiguous to Pima County." (Chapter II, Section 2, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

25. The Corporate Members of defendant Pima Foundation now elect by majority vote the Board of Trustees of that Foundation. (Chapter XI, Section 1, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

26. Two-thirds of the Board of Trustees of defendant Pima Foundation must be Corporate Members of the Pima Foundation. (Chapter VI, Section 4, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

27. Among the powers of the Trustees of defendant Pima Foundation is the power "to adopt and to propose to the Corporate Members contract limits for medical services, which when adopted by a majority vote of the Corporate Membership shall be binding upon all Corporate Members [.]" (Chapter V, Section 2, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

28. The voting power of Corporate Members of defendant Pima Foundation is limited to "the right to vote on the adoption of any contract limits for medical services by the [Pima] Foundation." (Chapter II, Section 3, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

29. The adoption of any "schedule for medical services" by the Corporate Members of defendant Pima Foundation is required to be "by mail ballot." (Chapter II, Section 3, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

30. Applicants for Corporate Membership in defendant Pima Foundation must complete and sign an application blank which contains an agreement "to be bound by any and all rules, regulations, committee decisions, contract limits, and the like, adopted by [the Pima Foundation]." (Chapter II, Section 5, October 1978 By-Laws of Pima Foundation, Exhibit N to Supplemental Rule 11(h) Statement on Liability.)

31. Over one thousand (1,000) medical doctors who reside in Maricopa County, Arizona, are participating members of defendant Maricopa Foundation. (Maricopa Foundation's Admission No. 268; Exhibits MF-51, MF-64 (§ I, ¶10); and MF-112 through MF-118 to Plaintiff's First Request for Admissions.)

32. Over four hundred (400) doctors who reside in Pima County, Arizona, are participating members of defendant Pima Foundation. (Affidavit of Thomas P. Finley attached to Pima Foundation's Opposition [hereinafter "Finley Affidavit"] ¶7, Opposition of Defendant Pima Foundation to Plaintiff's Motion for Partial Summary Judgment on the Issue of Subject Matter Jurisdiction (hereinafter "Pima Foundation's Opposition"), at 14; Gerdenics Deposition, at 27-28 and Exhibits 6, 45, 46, 48 § 1, ¶8; Exhibit PF-125 to Plaintiff's First Request for Admissions.)

33. The participating and cooperating members of the defendant foundations have periodically executed applications for foundation membership. (Maricopa Foundation's Admissions No. 13, Gerdenics Deposition at 27, 28 and Exhibit 46; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. II, at 49-50 and Exhibit 55.)

34. Applications for participating and cooperating membership in the defendant foundations have contained an agreement that the foundation member will be bound by the foundation fee schedule. Maricopa Foundation's Admissions No. 14; Pima Foundation's Admissions No. 14; Exhibits PF-123 and MF-112 through MF-118 to Plaintiff's

First Request for Admissions; Gerdenics Deposition at 27-28 and Exhibit 46, ¶2; Mitten Deposition Exhibit 55, ¶5)

35. Defendant Maricopa Foundation has consistently maintained as members over 70 percent of the private practicing M.D.'s and approximately one-half of the osteopathic physicians in Maricopa County. (Exhibit A to McLain Affidavit Exhibit MS-51 to Plaintiff's First Request for Admissions.) 1979 Maricopa Foundation Bid to Department of Economic Security.

36. The defendant foundations have represented to their members and other doctors that the foundations have been working to protect the interest of doctors who practice on a fee-for-service basis. (Maricopa Foundation Admissions No. 91; Pima Foundation Admissions No. 213.)

37. The defendant foundations have prepared and published fee schedules for doctor's services. (Maricopa Foundation Admissions Nos. 44, 54, 250, 57, 58, 169, 176; Pima Foundation Admissions Nos. 57, 58, 346, 350, 356, 365-368, 375, 402, 409.)

38. The defendant foundations have proposed fee schedules to their members for approval by mail ballot. (Maricopa Foundation's Admissions Nos. 34, 36, 156-158, 164, 234, 235; Pima Foundation's Admissions Nos. 34, 347, 348, 362, 363, 402, 409, 412, 423, 425; Deposition of Anthony Mitten (hereinafter "Mitten Deposition" Vol. I at 114-118, Vol. II at 10-11.)

39. Defendant Pima Foundation has adopted fee schedules by mail ballot of its participating and cooperating members on at least the following occasions:

1. Jan. 1974
2. May 1976
3. Oct. 1976
4. Dec. 1977

(Pima Foundation's Admissions Nos. 34, 347, 348, 362, 363, 402, 403, 409, 412, 423, 425; Exhibits MF-1, MF-70, MF-88, MF-93, MF-95, MF-102 to Plaintiff's First Request for Admissions.)

40. Defendant Maricopa foundation has adopted fee schedules by mail ballot of its participating and cooperating members on at least the following occasions:

1. July 1974
2. Oct. 1975
3. Autumn, 1977

(Maricopa Foundation's Admissions Nos. 34, 36, 64, 156-158, 234, 235; Exhibits MF-1, MF-70, MF-88, MF-93, MF-95, MF-102 to Plaintiff's First Request for Admissions.)

41. The defendant foundations have referred to the fee schedules adopted by their members as "uniform fee schedules." (Chapter II, Section 5, By-Laws of Maricopa Foundation, Exhibit MF-122 to Plaintiff's First Request for Admissions; Chapter II, Section 5, By-Laws of Pima Foundation, Exhibit PF-183 to Plaintiff's First Request for Admissions;)

42. Defendant Maricopa Foundation has indicated in communications to their members and various groups of doctors that the foundation fee schedule should approximate the majority of doctors' charges. (Exhibits MF-3, MF-27 through MF-46 to Plaintiff's First Request for Admissions.)

43. The defendant foundations have made and entered agreements with certain insurers and other third parties that require the insurers and other third parties to pay for doctors' services to persons insured under foundation-approved plans at the prices set by the foundation fee schedules. (Maricopa Foundation's Admissions Nos. 10, 11, 12; Pima Foundation's Admissions Nos. 10, 11, 12; Gerdenics Deposition at 22-24, 110-112, Exhibits 5, 6, 48; Affidavit of Roger Beck, Exhibit A to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judg-

ment on the Issue of Subject Matter Jurisdiction (hereinafter Rule 11(h) Statement on Subject Matter Jurisdiction) (hereinafter "Beck Affidavit"), Exhibits A-2, A-3, A-4 and A-9; Affidavit of William A. DeWaal, Exhibit B to Rule 11(h) Statement on Subject Matter Jurisdiction (hereinafter "DeWaal Affidavit"), Exhibits B-1, B-2, B-14, B-15, B-18, B-19 and B-29; Mitten Deposition, Vol. I at 21-23, Exhibit 13.)

44. Defendant foundations have endorsed or approved certain health insurance plans which are underwritten by private insurers and other third parties and meet certain "minimum standards" formulated by the defendant foundations. (Beck Affidavit Exhibits A-3, A-4, A-5 and A-9; DeWaal Affidavit Exhibits B-6, B-14, B-17, B-26 and B-27; Gerdenics Deposition at 27-28.)

45. The minimum standards for the defendant foundations include, among other things, the maximum allowable rate of payment set by the foundation fee schedules for covered doctors' services to persons insured under foundation-approved plans. (Maricopa Foundations Admissions No. 10; Pima Foundation's Admissions No. 10.)

46. The minimum standards of the defendant foundations require the insurer or other third party that underwrites a foundation-approved plan to pay 100 percent of the fees charged by doctors up to the maximum amounts set by the foundation fee schedules for doctors' services covered under the plan. (Maricopa Foundation's Admissions Nos. 14, 16; Pima Foundation's Admissions Nos. 14, 16.)

47. Defendant foundations have expressly limited the "professional payments" made under foundation-approved plans to "duly-licensed:

(a) Physicians and Surgeons (Doctors of Medicine);
(b) Doctors of Dentistry;
(c) Physicians and Surgeons (Doctors of Osteopathy); and

(d) Doctors of Chiropody (Podiatrists)."

(¶5 of Exhibits PF-108 and PF-118 to Plaintiff's First Request for Admissions; § I ¶7 of Exhibits MF-64 and MF-101 to Plaintiff's First Request for Admissions.)

48. The maximum doctors' fees allowed by the foundation fee schedules are determined by the defendant foundations in concert with their members, not by the insurers and other third parties that pay for doctors' services to persons insured under foundation-approved plans. (Maricopa Foundation's Admissions Nos. 10, 11, 12; Pima Foundation's Admissions Nos. 10, 11, 12; Mitten Deposition Vol. I pp 21-23.)

49. To determine the price allowed for a doctor's service under a foundation fee schedule, one must refer to both a relative value schedule and a unit conversion factor. (Maricopa Foundation's Admissions No. 17; Pima Foundation's Admissions No. 17.)

50. Defendants and their members have agreed upon, used, revised, published and circulated relative value schedules prepared by the California Medical Association, the American College of Radiology and the American Society of Anesthesiologists. (Maricopa Foundation's Admissions Nos. 19, 21, 23, 160; Pima Foundation's Admissions Nos. 19, 21, 23, 38, 323; Gerdenics Deposition, at 41-49, 82-26, Exhibit 18; Mitten Deposition, Vol. I at 71-82, Vol. II at 97-100; *see* Exhibits E, F, G, and H.) (to Statement of Undisputed Facts Supporting Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability hereinafter Supplemental Rule (h) Statement on Liability.")

51. Pursuant to consent orders to cease and desist in the cases styled *In re California Medical Association*, FTC File No. 781005 (FTC, filed November 14, 1977), and *In re The American College of Radiology*, FTC File No. 7610059 (FTC, filed September 13, 1977 the California Medical Association and the American College of Radiology have been enjoined from initiating, developing publishing, circu-

lating or advising the use of any actual or proposed relative value schedule or conversion factor and have been ordered to cancel, repeal, abrogate and withdraw any and all relative value schedules which they have previously developed, published or circulated. (California Medical Association Agreement containing Consent Order to Cease and Desist attached to this Statement as Exhibit C; American College of Radiology, Agreement containing Consent Order to Cease and Desist attached to this Statement as Exhibit D.)

52. A relative value schedule is a list or compilation of doctors' services which assigns a comparative unit value to each service listed. (Maricopa Foundation's Admissions No. 17, 18; Pima Foundation's Admissions Nos. 17, 18; Exhibits E, F, G, and H to Supplemental Rule 11(h) Statement on Liability; Gerdenics Deposition at 25, 41-49, Exhibit 18; Mitten Deposition, Vol. I at 70-96.)

53. A unit conversion factor is a number or dollar figure used to multiply the unit value found in a relative value schedule for any doctor's service into a dollar figure payable for that service. (Maricopa Foundation's Admissions No. 160; Exhibit MF-102 to Plaintiff's First Request for Admissions; Mitten Deposition, Vol. I at 96-100, Exhibit 28; Gerdenics Deposition at 28, 44.)

54. Foundation fee schedules provide unit conversion factors to be used with certain relative value schedules to determine the amounts to be paid to doctors for services, goods and products sold by doctors. (Maricopa Foundation's Admissions Nos. 93, 94, 95, 96, 229, 233, 304; Pima Foundation's Admissions Nos. 344, 349, 364, 413, 426; Exhibits PF-1, PF-146, MF-63 and MF-121 to Plaintiff's First Request for Admissions; Gerdenics Deposition, Exhibits 20, 25, 26, 27, 28 29; Mitten Deposition, Vol. I at 96-104, Exhibit 2.)

55. An increase in the relative value assigned to a specific procedure in the relative schedules adopted by the defendant foundations increases the resulting price for that procedure; an increase in the foundation conversion factor

for any category of medicine increases the resulting prices for all the doctors' services included in that medical category in the relative value schedules adopted by the defendant foundations. Gerdenics Deposition at 24-26, 41-49.

56. Defendant Maricopa Foundation has published a conversion manual to facilitate the use of foundation conversion factors with different relative value schedules. (Exhibit H to Supplemental Rule 11(h) Statement on Liability.)

57. In concert with their members and various groups of doctors, the defendant foundations have agreed upon, published, circulated and encouraged the use of the relative value schedules adopted by their members. (Maricopa Society's Admissions No. 197; Maricopa Foundation's Admissions Nos. 28, 32, 122, 136, 137, 139, 193, 248, 261, 262, 263, 283; Pima Foundation's Admissions Nos. 28, 32, 318, 319, 321-323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 399, 410, 414, 424; Mitten Deposition Vol. I at 73-84, 95-96.)

58. In concert with their members and various groups of doctors, the defendant foundations have adjusted the unit values assigned to various doctors' services in the relative value schedules adopted by their members as a means of adjusting the prices to be paid to doctors for services to persons insured under foundation-approved plans. (Maricopa Society's Admissions No. 197; Maricopa Foundation's Admissions Nos. 28, 32, 122, 136, 137, 139, 193, 248, 261, 262, 263, 283, 296; Mitten Deposition, Vol. I at 73-84, 95-96, Vol. II at 97-100, Exhibits 56, 65, 66; Pima Foundation's Admissions Nos. 28, 32, 318, 319, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 399, 410, 414, 424; Gerdenics Deposition, at 84-86, Exhibit 48, § V; Exhibits PS-1, PF-1, PF-127 through PF-129, MF-47, MF-64, § V, MF-99, MF-100, MF-107 and MF-107A to Plaintiff's First Request for Admissions.)

59. The unit values assigned to certain doctors' services in the relative value schedules used by the defendant foundations have been revised and adjusted by defendants in cooperation with groups of doctors who specialize in those services. (Maricopa Foundation's Admissions Nos. 44, 45, 46, 47-49; Pima Foundations' Admissions Nos. 44-49, 50-54.)

60. The defendant foundations have consulted with their members and various doctors' associations concerning the preparation of Foundation fee schedules. (Maricopa Foundation's Admissions Nos. 44, 54, 250; Pima Foundation's Admissions Nos. 44, 54, 319-338; Exhibits MF-3, MF-4, and MF-62 to Plaintiff's First Request for Admissions; Mitten Deposition, Exhibits 59, 61, 66.)

61. The defendant foundations have consulted with various doctors' associations with respect to:

(a) the relative value schedules and unit conversion factors which their members use or prefer; and

(b) the relative value schedules and unit conversion factors which their members consider appropriate for foundation fee schedules.

(Maricopa Foundation's Admissions Nos. 44, 54, 104, 105, 106, 107, 112, 113, 114, 122, 126, 134, 135, 137, 166, 167, 179, 183, 193, 237, 238, 255, 252, 253, 258, 260, 261, 262, 263, 283, 284, 285, 287, 290, 291, 292, 293, 295, 296; Mitten Deposition, Vol. I, at 96, Pima Foundation's Admissions Nos. 44, 54, 319, 320, 321, 322, 323, 326, 328, 329, 330, 331, 332, 333, 334, 335, 336, 360, 414; Exhibits PF-109, PF-113, PF-169 through PF-182, PF-184 through PF-194, MF-57, MF-58, MF-60, MF-65 through MF-67, MF-77, MF-81, MF-99, MF-100, MF-103 and MF-104 to Plaintiff's First Request for Admissions.)

62. Defendants have asked other associations of doctors to meet and agree on the fees and fee schedules to be used by their members and to report the results of their agree-

ments to the defendants. (Maricopa Foundation's Admissions Nos. 44, 54, 250; MF-47; Pima Foundation's Admissions Nos. 44, 54, 319-338; Exhibits MF-4, PF-109 to Plaintiff's First Request for Admissions.)

63. Defendant Maricopa Foundation has polled its members on the fees they usually charge for their services. (Maricopa Society's Admissions Nos. 60, 101-103, 117, 172, 173, 197; Maricopa Foundation's Admissions Nos. 57, 58, 169, 176.)

64. Defendant Maricopa Foundation has polled various doctors' associations concerning the relative value schedules and unit conversion factors which their members considered appropriate for future foundation fee schedules. (*See, e.g.*, Exhibits MF-6 through MF-19 and MF-27 through MF-47 to Plaintiff's First Request for Admissions; Maricopa Foundation's Admissions Nos. 44, 54, 123, 124, 130, 160, 256, 261, 269, 279, 281, 284, 285, 286, 287, 290, 291, 292, 293, 295, 300; Mitten Deposition, Vol. II, at 87-88, Exhibits 59, 61.)

65. Foundation fee schedules have been published and circulated to doctors throughout the State of Arizona after their adoption by the members of defendant foundations. Maricopa Society's Admissions Nos. 60, 101, 102, 103, 117, 172, 197; Maricopa Foundation's Admissions Nos. 57, 58, 169, 176; Pima Foundation's Admissions Nos. 356, 365, 366, 368, 375, 402, 409.)

66. Foundation fee schedules have been published in the regular publications of the defendant societies. (Maricopa Society's Admissions Nos. 60, 101, 102, 103, 117, 172, 173, 197; (Maricopa Foundation's Admissions Nos. 57, 58, 169, 176; Pima Foundation's Admissions Nos. 57, 58, 346, 350, 356, 365, 366, 368, 375, 402, 209; Exhibits PS-1 and MS-14 to Plaintiff's First Request for Admissions; Affidavit of Anthony D. Mitten dated December 11, 1978, ¶2.)

67. The defendant foundations have mailed copies of their fee schedules to their members. (PS-1, MS-14, MSFRA's 60, 101, 102, 103, 117, 172, 173, 197; MFFRA-57, 58, 169, 176; AFFRD 356, 365, 366, 368, 375, 402, 409.)

68. The defendant foundations have mailed copies of their fee schedules to doctors who were not their members with applications for foundation membership. (PS-1, MS-14, MSFRA's 60, 101, 102, 103, 117, 172, 173, 197; MFFRA-57, 58, 169, 176; AFFRD 356, 365, 366, 368, 375, 402, 409.)

69. Fee schedules established by the membership of defendant Maricopa Foundation have been distributed upon request to possible applicants to the Maricopa Foundation.

70. Foundation members have agreed to accept the payment allowed by the Foundation fee schedule as full compensation on assigned claims of Foundation policyholders. (Maricopa Foundation's Admissions No. 14; Pima Foundation's Admissions No. 14; Mitten Deposition, Vol. I, p. 110; Affidavit of Anthony D. Mitten dated November 17, 1978, ¶4; Exhibits PF-123, MF-112 through MF-118, MF-64, § 1, ¶10, to Plaintiff's First Request for Admissions; Gerdenics Deposition Exhibit 48, § 1, ¶3; Finley Affidavit ¶16; Pima Foundation's Opposition, at 3 ("[The Pima Foundation] sets maximum rates for various categories of covered health services.")

71. Foundation conversion factors have on occasion been set higher than average and median doctors' prices at the time of their adoption. (Maricopa Foundation's Admissions Nos. 227 through 234, 269, 276; Mitten Deposition, Vol. II at 92-94.)

72. Fee data collected by the Health Insurance Association of America and the Arizona Medical Association in 1975 and 1976 showed the median and average fees charged by doctors in Arizona during that period remained at the approximate level set by the foundation fee schedule. When the foundation conversion factors were increased, the median and average fees increased to the new level set by the

foundation fee schedule. (Maricopa Foundation Admisions Nos. 228-235 Exhibit MF-71 to First Request for Admissions.)

73. Defendant Maricopa Foundation has sent defendant Pima foundation copies of fee schedules adopted by the Maricopa Foundation, and the Pima Foundation has subsequently adopted those fee schedules. (Maricopa Foundation's Admissions Nos. 63, 170, 171, 186; Pima Foundation's Admissions Nos. 63, 358, 359, 361, 362; Gerdenics Deposition at 60; Mitten Deposition, Vol. II at 47-48, Exhibit 53; Exhibits PF-132, PF-135, PF-151 and PF-154 to Plaintiff's First Request for Admissions.)

74. Doctors' prices have had a direct and substantial effect on payments made and premiums charged for health insurance in the State of Arizona. (Maricopa Foundation's Admissions Nos. 143, 224; Mitten Deposition, Vol. I at 60-64. Vol. II at 6-10, Exhibits 20, 21, 32, 33; Finley Affidavit ¶21 DeWaal Affidavit Exhibits B-2 through B-7, B-9, B-16 and B-17.)

75. The defendant foundations have provided advance notice of expected increases in foundation fee schedules to the insurers and other third parties that underwrite foundation-approved plans. (Maricopa Foundation's Admissions Nos. 61, 155, 163, 220, 223, 236; Mitten Deposition, Vol. I at 22-25, 51-62, Exhibits 14-18, 22, 59; Pima Foundation's Admissions No. 61; Exhibits MF-92, MF-96 and MF-98 to Plaintiff's First Request for Admissions; DeWaal Affidavit, Exhibit B-9.)

76. The prices set by the foundation fee schedules have had a direct and substantial effect upon payments made and premiums charged for foundation-approved plans. (Maricopa Society's Admissions Nos. 146, 147, 188; Mari-

copa Foundation's Admissions Nos. 143, 188, 224; *See* Finley Affidavit 21; DeWaal Affidavit, Exhibits B-2 through B-7, B-9 and B-17; Mitten Deposition, Vol. I at 60-64, Vol. II at 6-10, Exhibits 20, 21, 32, 33.)

77. Defendant Maricopa Foundation has employed insurance consultants to estimate the increases in premiums on fundation-endorsed health insurance plans which would result from increases in the foundation fee schedules adopted by the Maricopa Foundation's membership. (Maricopa Foundation's Admission No. 143.)

78. Defendant Maricopa Foundation discussed and approved increases in the deductibles on foundation-approved insurance plans to offset increases in permiums that would have otherwise resulted from increases in the foundation fee schedules adopted by the foundation's membership. (Mitten Deposition Vol. I Exhibit 21 at 63-64).

79. In the year 1966, the State of Arizona paid approximately $75,867,000.00 to doctors in Arizona. (Plaintiff's Response to Maricopa Foundation's First Set of Interrogatories No. 9(A)).

80. In 1975, the State of Arizona paid approximately $280,279,000.00 to Arizona doctors, almost triple the amount it paid in 1966. (Plaintiff's Response to Maricopa Foundation's First Set of Interrogatories to No. 9).

81. The State of Arizona Division of Finance pays approximately 7.6 million dollars per year for health insurance premiums. (Plaintiff's Response to Maricopa Foundation's First Set of Interrogatories to No. 9).

82. In 1977, the State of Arizona paid the following amounts for health insurance premiums: approximately $5,877,000.00 paid to Blue Cross/Blue Shield of Arizona for coverage provided through Pima Care, ABC-HMO, and Blue Cross and Blue Shield Programs; approximately $1,332,500.00 paid to Connecticut General Insurance Company, Hartford, Connecticut, for coverage provided through the Arizona Health Plan; approximately $401,100.00

paid to Pacific Mutual Life Insurance Company, Newport Beach, California for coverage provided through a Maricopa Foundation-approved Plan. (Plaintiff's Supplementary Response to Interrogatory No. 3(A) of Maricopa Foundation's First Set of Interrogatories.)

83. Defendant Maricopa Foundation has provided administrative and peer review services for at least one health care program without setting the doctors' fees payable under that program. (Exhibit E-1 to McLain Affadivit.)

DATED: July 6, 1979.

(Signatures omitted in printing.)

EXHIBIT A

(Certificate of Incorporation omitted in printing.)

ARTICLES OF INCORPORATION
OF
THE ARIZONA MEDICAL ASSOCIATION, INC.

KNOW ALL MEN BY THESE PRESENTS:

That the undersigned, whose residences and post office addresses appear opposite their respective names, have this day associated themselves together for the purpose of forming a non-profit corporation under the laws of the State of Arizona and do hereby adopt the following Articles of Incorporation.

ARTICLE I

The name of this corporation is and shall be THE ARIZONA MEDICAL ASSOCIATION, INC.

ARTICLE II

The location of its principal place of business shall be at Phoenix, Arizona but it may establish other places of business and other offices at such other places within the State of Arizona as the Board of Directors may from time to time determine.

ARTICLE III

The objects, purposes and powers of this corporation and the general nature of the business it proposes to transact are:

(a) To bring into one organization the entire medical profession of the State of Arizona to promote the science and art of medicine; to promote and elevate the standards of medical ethics and medical education; to promote public health and in all instances and manners to operate as a

non-profit business league and scientific and educational organization for the above stated purposes; provided, however, that the corporation shall not in any manner carry on propaganda or otherwise attempt to influence legislation;

(b) To make gifts of real and personal property to corporations, trusts, community chests, funds or foundations created or organized in the United States or in any possession thereof or under the law of the United States or of any state or territory or of any possession of the United States organized and operated exclusively for charitable, scientific or educational purposes or for such business league purposes as shall be in furtherance of the aims of this corporation, no part of the net earnings of which inures to the benefit of any private shareholders or individual, and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation;

(c) To act as trustee of trust funds created solely for charitable, scientific or educational purposes or for such business league purposes as shall be in furtherance of the aims of this corporation;

(d) To buy, contract for, lease and in any other lawful ways acquire, take, hold, own and to sell, mortgage, lease and otherwise dispose of lands and all other kinds and classes of real property and rights and interests therein;

(e) To buy, contract for, lease and in any other lawful ways acquire, take, hold and own personal and mixed property of all kinds and to sell, mortgage, lease and otherwise dispose of the same;

(f) To buy, sell, hold, use, lease and deal in franchises, easements, licenses, privileges, patents, rights of way, trademarks and trade names;

(g) To borrow money and to issue bonds, debentures, notes and other evidences of indebtedness and obligations from time to time for any lawful corporate purpose and to mortgage, pledge and otherwise charge any or all of its properties, rights, privileges and assets to secure the payment thereof;

(h) To accept by gift, devise or bequest money, property or rights;

(i) To establish terms and conditions of membership in the corporation; and

(j) To do all and everything necessary, suitable and proper for the accomplishment of any of the purposes or attainment of any of the objects hereinbefore mentioned either alone or in association with other individuals, corporations or partnerships and including federal, state, county and municipal bodies and authorities and in general to do any and all things which a natural person could do or which now or hereafter may be authorized by law and in general to do and perform such acts and things and transact such business in connection with the foregoing objects not inconsistent with law in any part of the world.

ARTICLE IV

The time for the commencement of this corporation shall be the date of the filling of these Articles of Incorporation as required by law and the term of its corporate existence shall be twenty-five (25) years thereafter, with privilege of renewal as provided by law.

ARTICLE V

This corporation shall be a non-profit corporation and shall have no stock and no dividends or pecuniary profits shall be declared or paid to the members thereof or to any other private individual and all of its earnings shall be used to further the purposes of this corporation as hereinabove set forth.

ARTICLE VI

The members, officers and directors of the corporation shall not be individually liable for the corporation's debts or other liabilities and the private property of such individuals shall be exempt from any corporate debts or liabilities.

ARTICLE VII

The control and management of the affairs of this corporation shall be vested in a board of directors of not less than five nor more than twenty-five members and the names of those selected to serve beginning with the incorporation of this corporation and until their successors shall be chosen are:

Dr. Robert E. Hastings
Dr. Harry T. Southworth
Dr. H. D. Ketcherside
Dr. Frank J. Milloy
Dr. C. E. Yount, Jr.
Dr. Harry E. Thompson
Dr. Jesse D. Hamer
Dr. Thomas H. Bate
Dr. A. I. Podolsky
Dr. Walter Brazie
Dr. Herbert B. Potthoff
Dr. Preston T. Brown
Dr. Robert S. Flinn
Dr. Harold W. Kohl
Dr. Donald E. Nelson
Dr. Hugh C. Thompson

The above directors were elected at a meeting held in Phoenix, Arizona on the 3rd day of May, 1950.

The Board of Directors shall have the right to increase and decrease within the limits above set forth the number of directors of the corporation and shall have the right to fill any vacancy in the Board of Directors in the manner

provided in the By-Law. The Board of Directors shall have full power to adopt, alter and amend By-Laws and to make proper rules and regulations for the transaction or the affairs of the corporation.

ARTICLE VIII

There shall be such class or classes of membership as may be set forth and provided for in the By-Laws of this corporation together with such voting privileges and other privileges, obligations and rights as therein set forth.

ARTICLE IX

No member shall possess any property right in or to the property or assets of the corporation. In the event of the dissolution or winding up of the corporation, all assets not otherwise disposed of and not subject to any trust shall be given, granted and conveyed to the American Red Cross.

ARTICLE X

These Articles of Incorporation may be amended by the affirmative vote of a majority of the members present at a meeting called for that purpose, provided that in no event shall Article V hereof be altered or amended in any manner whatsoever; and, provided further, that notice of proposed amendment or amendments shall be given by written notice the directors at least ten (10) days prior to said meeting, and by a publication once a week for two (2) successive weeks prior to the meeting in a newspaper of general circulation in the county wherein these Articles of Incorporation were published. Amendments shall be signed and acknowledged by the president and attested by the Secretary of the corporation and shall be filed, recorded and published as articles of incorporation of private corporations are required to be; provided, however, that such publication can be dispensed with when each member signs a waiver notice.

ARTICLE XI

Hereafter, the Board of Directors shall be elected at the regular annual meeting of the members which shall be held alternately in Phoenix and Tucson, Arizona, beginning with Tucson, Arizona in the year 1951 on the first Sunday of April of each year.

Each director shall hold office for a term of three (3) years or for such shorter period as he may have been elected or until his successor shall have been elected and qualified. The terms of office of directors Robert E. Hastings, M.D., H. D. Ketcherside, M.D., Frank J. Milloy, M.D., C. E. Yount, Jr., M.D., Harry E. Thompson, M.D., Jesse D. Hamer, M.D., Robert S. Flinn, M.D., Hugh C. Thompson, M.D., Preston T. Brown, M.D., and Herbert B. Potthoff, M.D., shall expire at the time of the next annual meeting in 1951; the terms of directors Harry T. Southworth, M.D., Harold W. Kohl, M.D., Walter Brazie, M.D., and Thomas H. Bate, M.D., shall expire at the time of the annual meeting in 1952; and the terms of directors A.I. Podolsky, M.D., and Donald E. Nelson, M.D., shall expire at the time of the annual meeting in 1953.

The members shall elect from among themselves a President, a Secretary and a Treasurer, and such other officers as shall be designated by the members from time to time. The time and the place of electing said officers and the terms of their office shall be fixed by the By-Laws.

ARTICLE XII

The highest amount of indebtedness or liability, direct or contingent, to which this corporation may be subject at any one time shall be such amount or amounts as may be authorized by three-fourths (¾ths) of the votes cast with respect thereto at a lawfully held meeting of the members of the corporation and approved by the Arizona Corporation Commission.

ARTICLE XIII

This corporation does hereby appoint Edward Jacobson of Phoenix, Arizona, who has been a bona fide resident of the State of Arizona for at least three years, its lawful agent in and for the State of Arizona for and on behalf of said corporation to accept and acknowledge service of, and upon whom may be served, all necessary process or processes in any action, suit, or proceeding that may be had or brought against said corporation in any of the courts in said State of Arizona, such service of process or notice or the acceptance thereof by said agent endorsed thereon to have the same force and effect as if served upon the President and Secretary of said corporation.

The foregoing appointment may be revoked at any time by filing an appointment of a successor agent.

IN WITNESS WHEREOF, we, the undersigned, have hereunto signed our names this 16th day of June, 1950.

(Signatures omitted in printing.)

EXHIBIT C

Agreement Containing Consent Order to Cease and Desist, *In the Matter of California Medical Association*, FTC File No. 781 0005, November 17, 1977

(Contents omitted in printing.)

EXHIBIT D

Agreement Containing Consent Order to Cease and Desist, *In the Matter of The American College of Radiology*, FTC File No. 761 0059, September 13, 1976

(Contents omitted in printing.)

EXHIBIT E

(Caption omitted in printing.)

AFFIDAVIT OF ALICE McLAIN

(Jurat omitted in printing.)

ALICE McLAIN, being duly sworn under oath, deposes and says:

1. I am Administrator of the Comprehensive Medical and Dental Program for Foster Children of the State of Arizona, Department of Economic Security, and as such am authorized to make this affidavit. I make these statements on the basis of facts within my personal knowledge.

2. The attached exhibits are copies of documents which were made and received in the ordinary course of business of the Comprehensive Medical and Dental Program for Foster Children of the State of Arizona, Department of Economic Security. They have been maintained in the ordinary course of business in the files of the Department of Economic Security and copies have been provided to the Attorney General of Arizona.

(Signatures omitted in printing.)

MARICOPA FOUNDATION FOR MEDICAL CARE

May 13, 1979

Ms. Alice McLain
CMDP Administrator
Department of Economic Security
P. O. Box 6123-940C
Phoenix, Arizona 85005

RE: Comprehensive Medical/Dental Program For Foster Children

Dear Ms. McLain:

Enclosed is the proposal from the Maricopa Foundation for Medical Care to continue the administration of the medical program for the Arizona Foster Children.

We feel our proposal responds directly to all aspects of the request for proposal from the Department of Economic Security.

Please feel free to contact me if there are clarifications necessary or if additional information is required.

Sincerely,

/s/ ANTHONY D. MITTEN
Anthony D. Mitten
EXECUTIVE DIRECTOR

ADM/hg

enc.

PREAMBLE

The Maricopa Foundation For Medical Care hereby submits the following proposal to continue to act as fiscal intermediary in the administration of the Comprehensive Medical and Dental Program for Foster Children under the authority of the State of Arizona.

The purpose of the Foundation's establishment in 1969 was to assure quality care at a reasonable cost to the public. Since July of 1970, the Foundation has performed medical review over one-half million claims for ambulatory medical services. Over 250 licensed, private practicing physicians review claims incuding M.D.'s, D.O.'s, and Podiatrists. During the past year, in relationship to our present administration of the Foster Children Program, we have established review teams of psychologists and licensed dentists.

Since August, 1971, the Foundation has been performing a Certified Hospital Admission Program (CHAP). This program is an institutional (hospitals and extended care facilities) review for pre-certification and certification of necessity of hospitalization and concurrent review of length of stay. We are presently monitoring over 1,000 hospital admissions per month in 26 hospitals in Maricopa County utilizing nurse coordinators and physician advisors. This type of hospital admission certification program has substantial effects in reducing the number of hospital days used for the plans monitored by the Foundation. Our statistics in 1978 indicated that the Foundation programs with CHAP had:

1. 441.8 admissions per 1,000.

2. 78.5 days per 1,000.

We feel that the Foundation concept has demonstrated its ability to be cost-effective while maintaining the highest quality of medical care. Our association with the Medical Society gives us the necessary physician cooperation and

control to continue to offer the Foster Children Program an effective review system, not only for medical care but for all other aspects of the comprehensive medical and dental program for the Foster Children.

In the following pages, we will discuss the operation of the Foundation in general and some specific aspects of the past years administration by the Foundation of the Foster Children Program.

II. BACKGROUND

The Maricopa Foundation For Medical Care was incorporated in 1969 in initially enrolled 85% of the active private practicing physicians in Maricopa County as participating members. The Foundation is a non-profit professional association composed of licensed Doctors of Medicine, Osteopathy and Podiatry engaged in the practice of medicine or surgery. Membership is voluntary and open to all Doctors of Medicine, Osteopathy and Podiatry in the state.

There are approximately 1500 active practicing M.D.'s available to private patients and 250 Osteopathic physicians in Maricopa County. The Foundation has consistently maintained over 70% of the private practicing M.D.'s and approximately one-half of the Osteopathic physicans as members. The majority of the Podiatrists in Maricopa County also participate in the Foundation organization. A copy of the 1979 Foundation membership book (Exhibit #1) is provided annually to each family covered by a Foundation-endorsed health plan.

The Maricopa Foundation started with seven sponsored groups in 1970 covering over 10,000 people and presently sponsors over 48 groups covering an estimated 100,000 lives in Maricopa County. Over 90,000 people in Foundation-endorsed plans have included the Certified Hospital Admission Program (CHAP) as part of their coverage.

The Maricopa Foundation has also operated claims processing and peer review of medical ambulatory services since its inception. Every claim for medical services is reviewed by a private practicing physician. This review takes place daily at the Maricopa Foundation office and review physicians are drawn from a pool of over 250 Foundation and non-Foundation physicians. A system for challenging review decisions has been established and operating since the inception of the Foundation program. Peer review physicians are reimbursed at a rate of $60.00 per hour as are the CHAP medical advisors. Physicians are not reimbursed for committee meetings, Board meetings or other matters relating to peer review or CHAP. During the past year the Foundation has established a special committee for the Foster Children Program and has expended hundreds of man hours in developing quality-conscious and cost-effective review and procedures. A detailed review of the Foundation's activities in regards to the Foster Children Program will be provided in another section of this proposal.

The statistics concerning the operation of the Maricopa Foundation's claim processing aspect and peer review functions are enclosed (Exhibit #2). As can be seen by these statistics, a substantial proportion of all claims processed by the Foundation are adjusted. Our figures established that since inception of the Foundation, the adjustments to billed charges by physicians have saved Foundation-endorsed plan employees over $6,000,000.

Among the more than 48 groups currently sponsored by the Maricopa Foundation are Arizona's largest private employer, Motorola; the City of Phoenix, the City of Scottsdale, various school districts and other smaller private employers (Exhibit #3).

The Maricopa Foundation has instituted a computerized data collection system for CHAP which enables the reviewing physician to more closely monitor utilization of in-hospital services and cost of those services. We have also

developed computerized reporting for the Foster Children Program on a special basis and are currently reviewing the possibilities of integrating some computerization of the actual claims processing facility run by the Foundation.

CERTIFIED HOSPITAL ADMISSION PROGRAM (CHAP)

The Certified Hospital Admission Program is a prospective hospital utilization program combining pre-admission and concurrent peer review by physicians to determine medical necessity for hospital admission and length of stay. This system has been in operation in Maricopa County since June of 1971.

The Foundation's Certified Hospital Admission Program has received excellent cooperation from the hospitals in the Maricopa County area. Enclosed (Exhibit #4) is the Foundation's Declaration of Policy issued to hospitals in this locality which outlines the procedure followed by CHAP and the approval given to the program by the Phoenix Regional Hospital Council.

As will be noted in the material, the Foundation makes every effort to utilize the existing hospital utilization committees to assist them in the operation of the Certified Hospital Admission Program.

CHAP concepts evolved from growing Foundation experience with successful peer review and include the following characteristics:

- Active involvement of attending physicians
- Preadmission certification
- Feedback to participating physicians as to peer standards and norms
- Relevant information systems and diagnostics (abstracting system)

Dynamic involvement of attending physicians, who have primary responsibility for patient admissions, surgeries, and discharges, is integral to CHAP design. Prior to hospitalizing a CHAP patient, attending physicians submit to the

Foundation physician advisory staff, an application for pre-admission certification. An application may be denied on the grounds that care could more appropriately be provided on an outpatient basis, that a planned surgery is not considered medically necessary or that preparatory lab work has not been completed, when feasible, prior to hospitalization. "Denial" refers only to the fact that payment will not be made for unauthorized services; medical judgments are left to the discretion of the attending physician, who, however, has been apprised through the review process of contraindicative peer opinion.

In the event that pre-admission certification of payment is made, the case is assigned to a nurse coordinator who will perform several administrative functions on behalf of the physician advisor. Abstracting from the admission application and subsequently, the medical record, the nurse coordinator completes a document detailing in patient experience of each CHAP case. An initial length of day is certified as payable, in accord with regional norms based on diagnosis. A tentative discharge date is affixed to the patient's chart as a reminder to the attending physician that in order for health insurance benefits to be payable beyond the specified date, an extension request must be approved by the physician advisor.

Emergency Admissions. In case of emergency admissions a CHAP nurse coordinator will initiate the certification process on the hospital premises and review the chart. The admitting officer should notify the CHAP certification desk at the Foundation office of all emergency admissions as soon as possible.

If a patient should be in and out of the hospital over the weekend before a CHAP nurse is available, the *Foundation guarantees certification for that hospital stay.*

Business Office Relationship

To finalize the hospital copy of the Certification Form the nurse coordinator will need to retrieve the hospital copy from the business office on the day of or following discharge.

The nurse coordinator will finalize the Certification Form immediately if the actual stay is less or equal to the days certified.

The actual stay is more than the days certified and no extension was approved by a medical advisor the nurse coordinator will certify only total days approved. In the foregoing case excess days constitute the patient's own expense.

Patients who have Foundation-endorsed health insurance plans with the CHAP benefit are presumed to understand that in order to have insurance coverage of their hospitalization, Foundation certification is mandatory and that certification also concerns the length of their hospital stay.

Conduct on the Ward

When arriving on the hospital ward the CHAP nurse coordinator is instructed to:

1. Report to the head nurse (and/or the unit clerk for permission to use the chart.
2. Consult with the head nurse before visting any patient to make certain the patient is not occupied with treatment, etc.

Nurse coordinators are instructed to conduct patient visits with discretion as to the area of the hospital where the patient is admitted. They will not, for example, visit psychiatric patients or those in ICU or CCU. Visits are conducted in a manner which will not disturb the patient. The nurse coordinator does not participate in care at the bedside.

The nurse coordinator realizes that she must fit her activity into the work flow of the hospital and will do so, tactfully.

Admitting Office Relationship

Elective admissions are pre-certified before the admission date. Printed notice of pre-certification will be presented to the admitting office before the patient appears (24 hours in advance of date of admission). The *Hospital Certification Control Form* will indicate initial certification for a specified number of days.

The hospital copy will not be in its final form until the patient is discharged and should not be relied upon for billing purposes until it has been finalized (indicating the TOTAL DAYS CERTIFIED).

The Role of the Nurse Coordinator in the Hospital

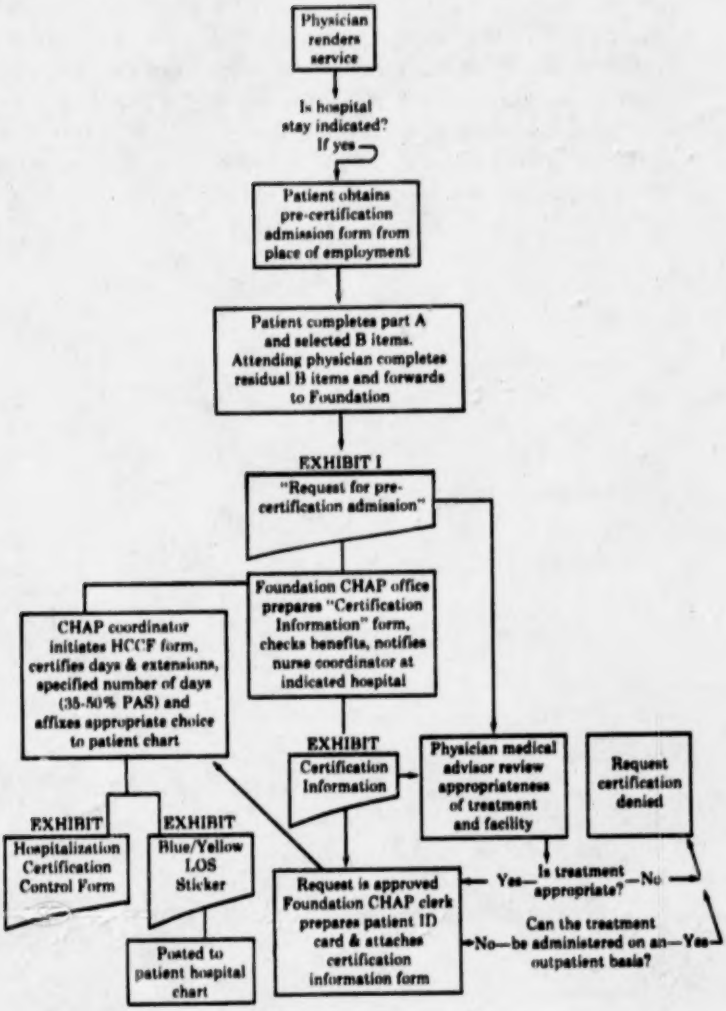
Both elective and emergency hospital admissions are certified. Initial certification is based upon statistical data found in the report of the *Commission on Professional and Hospital Activities* (1973 Regional PAS Study). Final certification is based upon each patient's personal progress, his unique medical need and individual nursing care requirement.

The CHAP nurse coordinator visits a CHAP insured patient during hospitalization to follow his progress and answer any questions the patient may have concerning insurance benefits.

In some instances the stated diagnosis may change, complications may be diagnosed or the surgery performed may be a different operation than was scheduled ... in these cases the nurse coordinator has documented reason to recode accordingly and amend the certification.

All extensions are determined by the *medical review physician team* in consultation with the attending physicians and not by the nurse coordinator.

The nurse coordinator visits the patient and reviews the chart on an on-going basis. Should an *extension* be requested by the attending physician she will have the information that the medical advisors may request for rendering an opinion of medical necessity for extension of hospital benefits. *No hospital benefits will be terminated without direct communication between the review physician and the attending physician.*


Physician renders service
Is hospital stay indicated? If yes
Patient obtains pre-certification admission form from place of employment
Patient completes part A and selected B items. Attending physician completes residual B items and forwards to Foundation
EXHIBIT I
"Request for pre-certification admission"
Foundation CHAP office prepares "Certification Information" form, checks benefits, notifies nurse coordinator at indicated hospital
CHAP coordinator initiates HCCF form, certifies days & extensions, specified number of days (35-50% PAS) and affixes appropriate choice to patient chart
EXHIBIT
Certification Information
Physician medical advisor review appropriateness of treatment and facility
Request certification denied
EXHIBIT
Hospitalization Certification Control Form
EXHIBIT
Blue/Yellow LOS Sticker
Posted to patient hospital chart
Request is approved Foundation CHAP clerk prepares patient ID card & attaches certification information form
Yes
Is treatment appropriate?
No
Can the treatment be administered on an outpatient basis?
No
Yes

This simple process is rarely adhered to in all its aspects and a myriad of complications may arise. The nurse coordinator makes the program work by keeping it responsive on a day-to-day basis to those mitigating circumstances which conspire to complicate the simple model.

The following diagram (Figure #1) illustrates the operation of CHAP. An outline of the activities of the CHAP nurse coordinator follows to indicate these duties in relation to the hospital. All decisions relating to the certification of hospitalization extension or denial of hospital days are made by the physician advisor.

AMBULATORY PEER REVIEW

As part of its administration of Foundation sponsored health insurance plans, the Foundation operates a system of professional review to insure the delivery of only appropriate, quality health care. Approximately 50 plans are now being reviewed, with 80,000 lives covered for both inpatient and ambulatory care.

Professional review procedures are closely coupled with claim processing activities, with particular attention paid to accurate coding. Claim data is entered onto manually maintained patient profiles used in the review process.

Review decisions are indicated on the claim and it is returned to the payment process.

The Foundation has developed broad guidelines of review criteria and made them available to its members so that they may fully comprehend the process of review (Exhibit #5).

Following is a brief outline of the history and purpose of peer review and an actual step by step procedure that the reviewing physician follows:

1. Initially a major peer review committee, comprised of various specialty representatives was established. In groups of two or three, this committee reviewed daily all of the claims submitted to the Foundation for payment.

2. As the committee became familiar with daily claim review an additional fifty physicians were integrated into the committee for the daily review. Two of the new physicians reviewing with one of the original physicians create a continuity that has worked well and evolved to establishing suggested guidelines as a common base to make the decisions somewhat consistent.

3. Copy of Suggested Guidelines was sent to each Foundation participating physician for his information.

4. A prerequisite for physicians serving on the Physicians Medical Review Committee is that they be in private practice, thereby being confronted with the same daily problems that are present in the practice of the physicians claims that he is reviewing. Therefore, each claim should be reviewed by a physician practicing in the same medical specialty field.

5. Our experience has shown that a reviewing physician is better able to relate a decision to the physician submitting the claim if communication is established by a telephone call rather than a written correspondence. Oral communication between the peer review committee and physician reviewed can not be over-emphasized as a means of better understanding and resolving problem areas.

Procedures for Reviewing Physicians

A. Purpose of Review: to answer these questions

1. Does the diagnosis given warrant the service rendered?

2. Do the service rendered warrant the fees charged?

B. Method of review: the following procedure is suggested

1. Scann the *COMPUTATION SHEET*. This sheet is attached to the inside cover of the family folder enables the reviewer to quickly familiarize himself with:
   a. Number of visits made by the patient.
   b. Services received by the patient.
   c. Previous medical expenses.
   d. Similar information for each member of the insured's family.

   Thus the computation sheet allows the reviewer to judge whether the patient or family might be thought to be overutilizing medical care and if so does this utilization involve one or several physicians.
2. Check the *PHYSICIAN REVIEW FORM*. This form furnishes information on the *claim* being reviewed.
   a. Diagnosis.
   b. Services rendered.
   c. Charges for services.
   d. Foundation's allowable charged for these services.

   From the Physician Review Form one can answer fundamental questions: Does diagnosis seem reasonable, does the diagnosis justify the services provided, do the charges seem reasonable?
3. Sign the *PHYSICIAN REVIEW FORM*. At this point you must do one of the following:
   a. Approve the claim for payment.
   b. Refer the claim to an appropriate specialist.
   c. Refer the claim to "team review".
   d. Refer to the Major Review Committee.
4. Check appropriate box if in your opinion there is suggestion of overutilization by patient or family or if there is over provision by the physician.

The following flow sheet demonstrates the operation of claims processing and physician peer review of ambulatory services (Figures 2 and 3).

FIGURE 2
CLAIMS PROCESSING

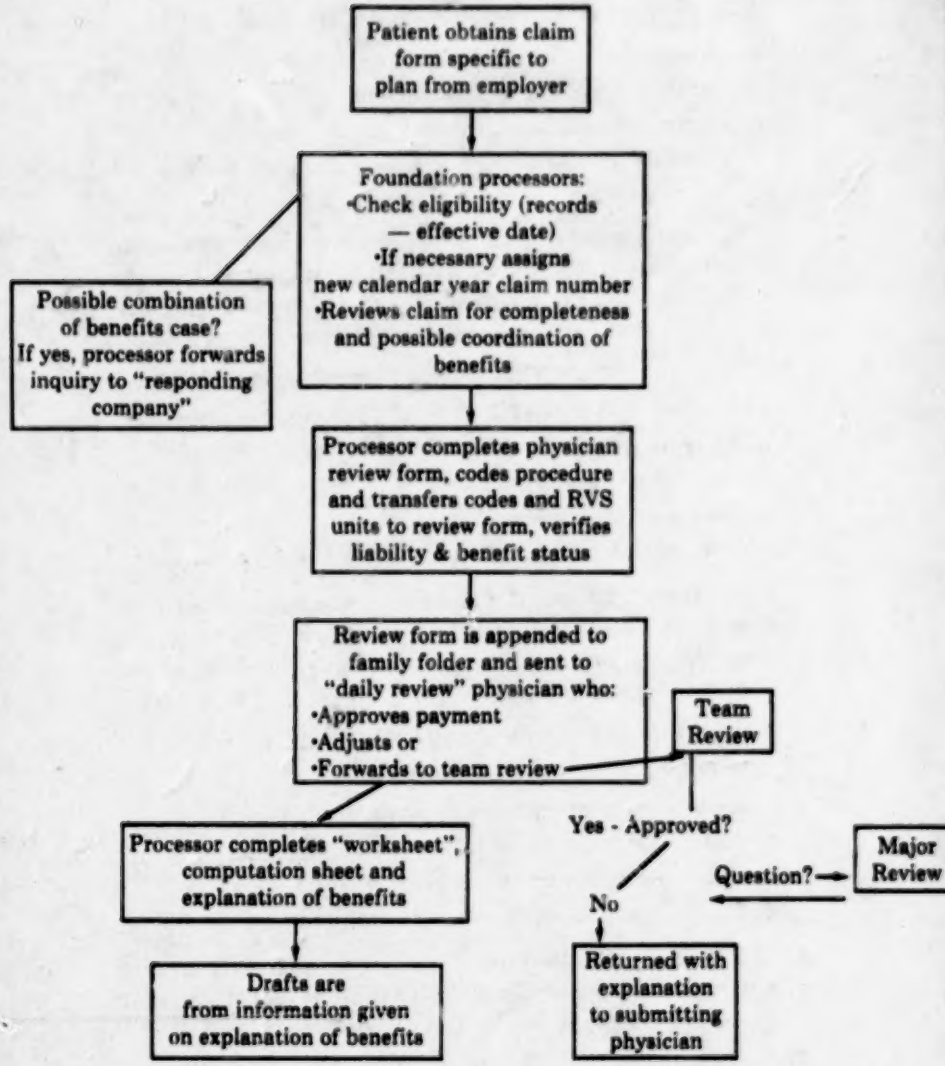
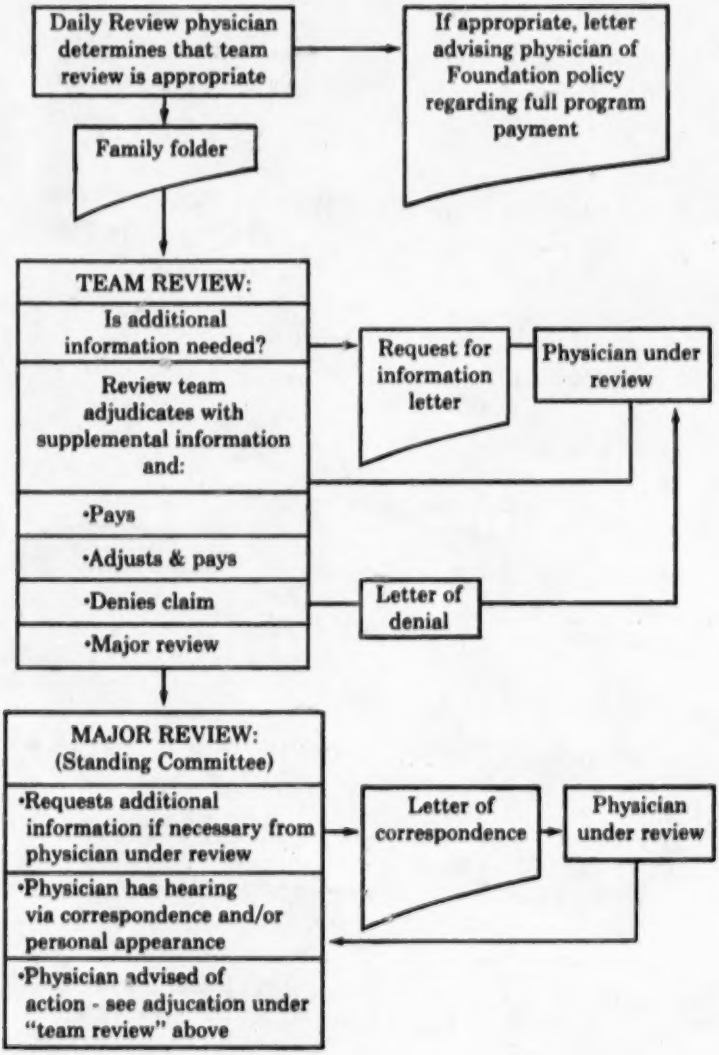


FIGURE 3
PHYSICIAN REVIEW



FOSTER CHILDREN PROGRAM - 1978-1979

The following is a brief review of the administration by the Foundation of the Foster Children Program since the award to the Foundation of this program, effective July 1, 1978. This is both an outline of our actions to date and a proposal to continue these procedures for the coming fiscal year.

PEER REVIEW-AMBULATORY CLAIMS-MEDICAL & SURGICAL SERVICES

In the review of medical and surgical services provided on an ambulatory basis, we feel that the regular Foundation's peer review would be, and has been, adequate insuring quality care and efficiency of cost. With modifications to indicate a prior authorization aspect of the Foster Children Program and the agreement of the provider to accept payment as payment in full, we have adopted the standard health insurance claim form for this program as well as the previously used prior authorization form for medical or surgical services. These forms are included in this proposal for review (Exhibit #6). As required by the program the authorization for medical equipment and/or supplies has been utilized as previously designed and is included as part of Exhibit #6.

PEER REVIEW-OUTPATIENT PSYCHIATRIC & PSYCHOLOGICAL SERVICES

As has been noted in the past, the history of the Foster Children Program indicates that a considerable proportion of the expenditures are for psychiatric or psychological treatments. This type of special problem has required an intensified effort on our part and has led to the development of a special prior authorization form, which was developed with the assistance of local psychiatrists, psychologists and other specialists. This new form (Exhibit #7) will permit a greater control of the program and provide considerably more data for continuing review.

PRIOR AUTHORIZATION-OUTPATIENT SERVICES

The medical and surgical review section of the Foundation has been expanded to include the requirement of prior authorization of the listed services as shown in the request for proposal from the Department of Economic Security. As indicated in the previous paragraph, the forms used by the Foundation for this are shown in Exhibit 6 and 7 and would be continued during the forthcoming year since they have proved to be effective in securing the information necessary to fulfill the statuatory requirements and to fulfill the needs of the medical reviewers involved.

CERTIFIED HOSPITAL ADMISSION PROGRAM (C.H.A.P.)

The CHAP concept has been outlined in detail in an earlier part of this proposal and has demonstrated its effectiveness over the years. This program pre-certifies the need for hospitalization and the length of stay for the procedure involved and fits in well with the statuatory requirements of the Foster Children Program. Prior authorization for elective surgery and concurrent review of this type of patient for the Foster Children Program has and will present no difficulty since the Foundation has performed these services for private groups throughout the state since 1971.

The prior authorization form, especially developed for psychiatric and psychological services lends itself to the special needs of this program on an inpatient basis also and will be continued to be used. In addition, the special Foster Children Committee has developed suggested criteria for hospitalization which have been approved by the Foundation Board and forwarded to the Department of Economic Security in March of this year (Exhibit #8). In addition, the Committee has implemented a recommended letter to all juvenile court judges recommending that the initial length of stay in court-ordered admissions be limited to 30 days. In reviewing the situations on court-ordered admis-

sions during the past few months it became apparent th some stays were ordered for periods over and above those medically necessary and it would seem more efficient to require shorter initial court-ordered admissions with continuation of the admission if medically necessary after review and discussion with the attending psychiatrist or psychologist. These recommendations, and others which will be forthcoming, are the results of many months work by the Committee and we are certain will prove to be beneficial to the program as times goes on.

DENTAL REVIEW-PRIOR AUTHORIZATION

The form previously used for prior authorization of dental treatment and as a statement for the dentist's actual services was adopted by the Foundation and is presently in use. During the past months, since the initiation of the Foster Children Program with the Foundation, we have established a comprehensive dental review program with the cooperation of the Central District Dental Society and have updated the dental criteria used for review. The Foundation has also met with the Pedodontists who are specialists in dental care of children and are looking forward to their special recommendations concerning coverage of dental care by the Foster Children Program. It is their recommendation that certain coverages be changed, which will be cost-effective, while maintaining quality of dental care necessary for those covered by this program. The pedodontists have been involved in the review process and we feel we have made significant strides in the dental aspects of this program.

SPECIAL NOTE

We feel that the Foundation has made significant strides in all aspects of review and administration of this program as required of a responsible fiscal intermediary employed

by the state. This is not to say that all problems involving the program have been solved but progress has been made and we feel that continuation of administration by the Foundation will be necessary if the progress is to continue.

We have had excellent cooperation from the Department of Economic Security personnel and from the providers of care, both institutional and individuals, throughout the state. The foregoing information responds to the request for proposal, (Exhibit #B) in regards to the medical evaluation system, the claims processing systems and the prior authorization procedures.

The Foundation will agree to make payment of the usual customary and reasonable costs of the covered service for the eligible foster children based upon the maximum allowable fee as scheduled by the Department of Economic Security as amended from time to time. We have maintained the current eligibility files as required and include as Exhibit #9 the description of the computerized system. Coordination of benefits section has been performed, as outlined in Exhibit B of the request for proposal, and we have provided the Department of Economic Security with an experienced employee for their staff to handle the portion of the coordination of benefits.

REPORTS

The Foundation has prepared the reports as required by the request for proposal and they are identical to the system requested in 1978. Included as Exhibit #10 is an outline of certain portions of these reports which are intended as examples of the type of reports provided and not as a complete listing of every report. We feel that our proposal conforms in every aspect to the Departments request for a proposal and look forward to continuing as fiscal administrator of this program.

BUSINESS PROPOSAL

The Foundation feels that a monthly charge of 13,900 will be necessary in order to provide the previously described services. We arrived at this figure based on our estimations of the number of personnel necessary to perform an adequate claims administration service and statistical reporting service plus the addition of peer reviewers as previously described. Out past years experience in this program has indicated certain areas which need to be increased in work load and we feel that this figure, which approximates 5.1% of the allocation for the program for fiscal 1979-1980 is most appropriate.

The following is a description of the type of personnel and the approximate cost to the Foundation for those services. We would be willing to sign a contract for the flat amount of $13,900 per month for the contract period and would be willing to abide by the figure provided there was no more than a 15% increase in the number of covered individuals during the contract year. If this figure of 15% were exceeded, the Foundation feels some reasonable adjustment would be necessary in the maximum monthly fee.

The personnel and costs at this state are as follows:

Coding Personnel — It is necessary that a uniform coding of claims be adopted and this is only possible with experience coding personnel to make certain the service provided is adequately described by the code. There may be adjustments necessary in the codes as submitted which require medical decisions and the Foundation is equipped by its experience and personnel makeup to provide the expertise. From the statistical information provided by the Department of Economic Security it is apparent that this group generates a higher number of claims than might be generated by a business firm of the same size.

$ 750.00

Claim Examiner/Reviewers — These are experienced claim processors who also work with the physician reviewer in doing the administrative work required of the claim in the processing aspect and following up to the conclusion the directions provided by the physician reviewer. In the Foundation model additional experience is necessary over and above a typical claims processor since the claim examiner in the Foundation model works as a team with the physician review panel.

$ 1,900.00

Clerical Personnel — The clerical functions of mail room activities, matching the claim with the files and forwarding the appropriate material to all parties concerned requires two clerks and filing personnel for this program.

$ 1,500.00

Data Analyzing and Reporting Personnel — These persons will analyze the claims to provide the information outlined in the Request for Proposal and any special information required of the current program by the Department of Economic Security. The Foundation has developed a computerized reporting system for the Foster Children Program even though we maintain the majority of our regular outpatient services on a manual statistical system. The input for the computerized system requires special personnel and these have been provided by the Foundation. We feel that the system as is presently constituted fulfills the peculiar needs of the Foster Children Program and has considerable additional information available if the need arises for that data.

$ 900.00

Data Reports — Required by D.E.S. — These particular reports were not included in the Request for Proposal last year and the Foundation's charges were

increased accordingly to provide this data to the Department of Economic Security. The charge includes systems support which is the design of the program and the hardware to implement the reports.

$ 1,000.00

Certified Hospital Admission Program — As mentioned earlier this program would run in the same manner as the present CHAP system and would employ nurse coordinators to administer the program in the hospital setting. Presently the Foundation has nurse coordinators who visit all the hospitals in this community. The number of coordinators would have to be increased in certain hospitals because of the increased work load and other arrangements would have to be made for hospitals outside of this community over and above the present arrangements which exist.

$ 2,400.00

Peer Review — The amount of reviewing time necessary to be provided by physicians and by other professionals such as dentists, podiatrists, psychologists, etc. would be approximately 50 hours per month. The Foundation presently compensates reviewers at a rate of $60.00 per hour.

$ 3,000.00

Administrative Support — The regular administrative support supplied to any group would be supplied to the Foster Children Program and it would include time provided by an assistant manager of claims, our Administrative Director and whatever additional administrative time provided by the Executive Director as necessary. This figure includes general office

overhead for a program of this size as well as all the preparation and printing of the special forms and booklets necessary for this program.

$ 2,450.00

Total $13,900.00

(Exhibits to Proposal deleted in printing.)

Remaining attachments omitted in printing.

EXHIBIT F

(Omitted in printing.)

Filed - JUL 6, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

PLAINTIFF'S MOTION FOR RECONSIDERATION OF MEMORANDUM AND ORDER OF JUNE 5, 1979, OR, ALTERNATIVELY, MOTION FOR CERTIFICATION FOR INTERLOCUTORY APPEAL PURSUANT TO 28 U.S.C. § 1292(b) OF MEMORANDUM AND ORDER OF JUNE 5, 1979

In the event that this Court does not grant plaintiff's concurrent motion for summary judgment and permanent injunction, plaintiff STATE OF ARIZONA respectfully prays that this Court enter its order vacating the Memorandum and Order dated June 5, 1979 insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability and that this Court grant plaintiff's motion for partial summary judgment on the issue of liability. Alternatively, plaintiff STATE OF ARIZONA respectfully prays that this Court enter its order pursuant to 28 U.S.C. § 1292(b) that insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability the Memorandum and Order dated June 5, 1979 involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from that portion of the order may materially advance the ultimate termination of the litigation. These motions are based on the entire record in this matter and the following memorandum of points and authorities.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

THIS COURT'S DECISION IS CONTRARY TO THE WELL ESTABLISHED UNDERSTANDING OF THE RULE OF REASON AND THE *PER SE* RULE AS DEFINED BY THE UNITED STATES SUPREME COURT

Whatever may be said for or against the *per se* analysis of other antitrust violations, its application to horizontal price-fixing cases had never been seriously questioned until this Court's recent opinion. Since this Court's error is no doubt due to plaintiff's failure to explain the *per se* rule and its application, we take this opportunity to attempt to remedy our past deficiency.

The *per se* standard is an analytical subset of the Rule of Reason, not its counterpoint. As Justice Stevens recently explained:

> [P]roperly understood, rule of reason analysis is not distinct from "*per se*" analysis. On the contrary, agreements that are illegal *per se* are merely a species within the broad category of agreements that unreasonably restrain trade; less proof is required to establish their illegality, but they nonetheless violate the basic rule of reason. *United States v. United States Gypsum Co.*, 98 S.Ct. 2864, 2892 (1978) (footnote omitted) (Stevens J. concurring in part and dissenting in part.)

Development of a *per se* rule for certain violations of the Sherman Act began with Chief Justice White's seminal opinion in *Standard Oil Co. v. United States*, 221 U.S. 1,

31 S.Ct. 502 (1910).[1] Faced with the all-inclusive language of section 1 of the Sherman Act, which prohibited "[e]*very* contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce," 15 U.S.C. § 1 (emphasis supplied), and was "broad enough to embrace every conceivable contract or combination which would be made concerning trade or commerce," the Chief Justice reasoned that the statute "contemplat[ed] and requir[ed] a standard." 221 U.S. at 60, 31 S.Ct. at 516. The standard which the Supreme Court adopted for Sherman Act analysis was the standard of reason which had been applied at the common law and in this country in dealing with [restraints of trade]." *Id.*

In canvassing the legal standards which had been applied to restraints of trade, Chief Justice White determined that certain restraints which had the effect of leading towards the evils of monoply had been consistently barred by the courts. Those restraints included:

(1) the power . . . to fix the price and thereby injure the public;

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[1] Judge (later Chief Justice) Taft's opinion in *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *aff'd*, 175 U.S. 211, 20 S.Ct. 96 (1899), complements Chief Justice White's opinion in *Standard Oil*. In *Addyston*, the court ruled that an agreement by members of an association of cast iron pipe manufacturers to eliminate competition among themselves was invalid under the Sherman Act because the agreement was not ancillary to any legitimate purpose. Under the "ancillary purpose" doctrine, a contract which had an effect of restraining trade might still be sustained if that part of the contract which restrained trade was ancillary or necessary to the achievement of a legitimate aim of the contract. 85 F. at 282-83. For example, a contract for the sale of a business might reasonably restrict the ability of the seller to compete with the buyer because the restrictive covenant is a means "of securing the seller against an increase of competition of his own creating [and is] necessary to promote the free purchase and sale of property." *Id.* at 281. *See Mitchel v. Reynolds*, 1 P. Wms. 181, 24 Eng. Rep. 347 (1711) (upholding as reasonable a restrictive covenant in the sale of a business).

(2) the power ... of enabling a limitation on production; and
(3) the danger of deterioration in quality of the monopolized article .... *Id.* at 52, 31 S.Ct. at 512.

The "contracts" and "other acts" which Chief Justice White said produced those evils and therefore offended the Sherman Act were defined by the Chief Justice as *"all* contracts or acts which were unreasonably restrictive of competitive conditions." *Id.* at 58, 31 S.Ct. at 515.

Under the Rule of Reason standard which the Supreme Court has followed since the Standard Oil decision, unreasonableness can be based "either (1) on the nature or character of the contracts, or (2) on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 690, 98 S.Ct. 1355, 1364 (1978), *citing Standard Oil.*

> In the first category are agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality - they are "illegal per se" in the second category are agreements whose competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed. In either event, the purpose of the analysis is to form a judgment about the competitive significance of the restraint .... 435 U.S. at 692, 98 S.Ct. at 1365.

The rule of reason, therefore, is primarily a standard which gauges the economic significance of a challenged act, agreement or understanding and weighs its effect on competition and its tendency towards the enhancement of prices, limitation of output or deterioration of quality. The analysis which is subsumed in the *per se* rule is but a subset of the analytical framework which Chief Justice White first described as the "rule of reason;" that analysis applies to those agreements which because "of their pernicious ef-

fect ... and lack of redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 518 (1968).

In deciding whether conduct should be characterized under the *per se* rule, the inquiry focuses on "whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output, and in what portion of the market, or instead one designed to 'increase economic efficiency and render markets more rather than less competitive.' " *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 99 S.Ct. 1551, 1562 (1979), *quoting United States v. United States Gypsum Co.*, 98 S.Ct. at 2873 n.13. Because of the unique place of price in our economic system, agreements among competitors regarding prices have always been placed in the category of those which — in the words of Chief Justice White and more recently of Justice Stevens — are because of the "nature of the contracts" *per se* illegal. *"Any combination* which tampers with the price structure is engaged in an unlawful activity. ... The act places all such schemes beyond the pale and protects that vital part of our economy against *any degree* of interference." *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221, 60 S.Ct. 811, 843 (1940) (emphasis added). The prohibition against such agreements among competitors is absolute: "Price-fixing is *per se* an unreasonable restraint of trade. It is not for the courts to determine whether in particular settings price-fixing serves an honorable or worthy end." *United States v. National Association of Real Estate Boards*, 339 U.S. 485, 489, 79 S.Ct. 711, 714 (1950).

Direct action to establish uniform prices is the most obvious form of price-fixing. But it must be remembered that the ban against price-fixing reaches arrangements far more subtle than a simple agreement between competitors to charge the same price. For example, an agreement between

competitors to exchange price information is price-fixing where it merely slows the decline of prices in a falling market. *United States v. United States Gypsum Co.*, 98 S.Ct. 2864 (1978) *United States v. Container Corp. of America*, 939 U.S. 333, 89 S.Ct. 510 (1969); *see United States v. F M C Corp.*, 306 F. Supp. 1106, 1159 (E.D. Pa. 1969). An agreement between competitors to refrain from advertising their prices reduces the significance of price as a competitive factor and is also illegal *per se* as price-fixing. *United States v. Gasoline Retailers Ass'n. Inc.*, 285 F.2d 688, 691 (7th Cir. 1961); *Louisiana Petroleum Retail Dealers, Inc. v. Texas Co.*, 148 F. Supp. 334 (W.D. La. 1956); Canby and Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 Duke L.J. 543, 578 (hereinafter "Canby and Gellhorn, *Physician Advertising*"). Even where there was no penalty for deviation from a price list on which the prices were denominated as "suggested" prices, the price list was not rigidly adhered to, and, indeed, there was not even an agreement to adhere to the price list, the agreement simply to prepare, adopt and circulate a suggested price schedule among competitors was held to be "such tampering with prices as is forbidden by the Sherman Act." *United States v. Nationwide Trailer Rental System, Inc.*, 156 F. Supp. 800, 805 (D. Kan. 1955), *aff'd per curiam*, 355 U.S. 10, 78 S.Ct. 11 (1957). *Accord, e.g., United States v. National Ass'n of Real Estate Boards, supra.* By like token, an agreement among automobile dealers to use a common price list merely as a starting point in negotiations was condemned as price-fixing. *Plymouth Dealers Ass'n v. United States*, 279 F.2d 128, 132 (9th Cir. 1960).

Only the pricing of a bulk product or service that is a unique aggregate and cannot be sold individually falls outside the *per se* category; the concerted pricing of individual goods or services has always been subject to the *per se* rule. This distinction was only recently underscored by the Su-

preme Court in *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 99 S.Ct. 1551, a case involving the issuance of blanket licenses to copyrighted musical compositions.

The BMI decision, which was unfortunately overlooked in this Court's Memorandum and Order of June 5, 1979, leaves no doubt that the *per se* rule is alive and well and is fully applicable to the horizontal price-fixing agreements at issue in this case. Through the blanket coypright license challenged in *BMI*, licensees received the right to perform any and all compositions owned by the numerous members of the defendant licensing agencies in exchange for fees which were generally based upon a percentage of the purchaser's total revenues or a flat dollar amount rather than the amount or type of music used. 99 S.Ct. at 1554-55. Noting that it had "never examined a practice like this one before", 99 S.Ct. at 1557, the Supreme Court conducted a first impression inquiry in order to determine whether the blanket coypright license should be categorized as a *per se* violation of the Sherman Act. Finding that blanket licenses had been permitted under consent decrees entered in previous antitrust litigation involving joint licensing agencies and had also been employed by Congress in the Copyright Act of 1976, the Court determined that blanket sales of copyrighted music were an essential means of protecting the rights of copyright owners while facilitating the economic use of their compositions in the entertainment industry. 99 S.Ct. at 1562-63. Because the single-fee blanket license was a unique product which no single copyright owner could offer individually, the Court found that the pricing of that single-fee blanket license did not constitute price-fixing. The licensing agent was not offering the individual goods of many sellers; it was a separate seller offering its own separate product in "a market in which individual composers are inherently unable to fully effectively

compete." 99 S.Ct. at 1564. The Court carefully and emphatically distinguished this situation from one where, as in the present case, competitors agree on prices for goods or services which they can and do sell on an individual basis.

> [T]he blanket license cannot be wholly equated with a simple horizontal arrangement among competitors. ASCAP does set the price for its blanket license, but that license is quite different from anything any individual owner could issue. The individual composers and authors have neither agreed not to sell individually in any other market nor use the blanket license to mask price-fixing in such other markets. 99 S.Ct. at 1564.

Noting that the plaintiff had not even alleged that the individual members and affiliates of ASCAP and BMI had "agreed among themselves as to the prices to be charged for the particular 'products' (compositions) offered by each of them[,]" 99 S.Ct. at 1564 n.42, the Court ruled that the blanket copyright license was not price-fixing and therefore was not subject to *per se* analysis.

Under the analytical framework which the Supreme Court employed in the *BMI* case, the doctors' fee surveys, fee agreements and fee schedules at issue in this case unarguably falls within the *per se* category.[2] Indeed, the defendants' price agreements are precisely the type of horizontal agreements on the price of individual goods and

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[2] Because such horizontal price-fixing agreements have already been determined by the Supreme Court to fall within the *per se* category, it is not necessary for this Court to repeat the first impression inquiry which the Supreme Court performed in BMI. Nor should the Court engage in Rule of Reason analysis with respect to those activities. *See, e.g.*, 99 S.Ct. at 1562 n.33 (indicating that if a burdensome analysis were to be conducted before a court could decide that a specific course of conduct fell within the *per se* category, the court might as well apply Rule of Reason analysis from the start in each case.) Because the record clearly demonstrates that the defendants' method of pricing the services sold by their individual members on a fee-for-service basis are precisely the type of arrangements which the Supreme Court has deemed subject to *per se* analysis, those inquiries are inappropriate here.

services which *BMI* describes as price-fixing within the *per se* category. *See* 99 S.Ct. at 1564. The goods and services which defendants' member doctors sell to persons insured under foundation-approved plans on a fee-for-service basis are no different than the goods and services which they sell to their other patients on a fee-for-service basis. The agreed-upon relative value schedules and conversion factors which are adopted by majority vote of the foundations' member doctors can be used and are used by those doctors to set the prices charged to all patients. Indeed, the defendants have repeatedly polled both member and non-member doctors to be sure that their "uniform fee schedules" will "approximate the charges of most physicians." (See Section II C of Memorandum in Support of Plaintiff's Motion for Summary Judgment and Permanent Injunction.)

If one were to seek in the medical marketplace an analogy to the "blanket license" which was at issue in the BMI case, it would be found in the group prepaid health plans, or "HMOs"[4] in which the patient purchases a "blanket right" to use the medical services of the plan's doctors in return for a flat capitation payment, not a payment based on utilization. *See generally* Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 Duke L.J. 487, 488-91 (hereinafter "Kissam, *HMOs.*") Because the capitation charge paid by the patient in those "package plans," has no correlation to the payment which the doctor receives for his or her services from the HMO, the setting of

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[4] The term "HMO" refers to a "health maintenance organization." While the term "HMO" is generally used to describe a group prepaid practice in which doctors' services are primarily provided by a "closed panel" of staff doctors who are reimbursed on a salaried or flat rate basis, it is sometimes also used in reference to an "open panel" plan or "independent practice association" in which doctors are reimbursed on a fee-for-service basis and do not work exclusively for the group practice. Only the former meaning is intended here. *See generally* Havighurst, *HMOs and the Market for Health Services*, 35 J. Law and Contemp. Prob. 716 (1970) (hereinafter "Havighurst, *HMOs*"); Kissam, *HMOs*.

that capitation charge could not "mask price-fixing" by doctors. *See* 99 S.Ct. at 1564. In the case of the defendant foundations, however, the very objective of the combination has been to maintain and promote the fee-for-service pricing system in which the doctor's reimbursement is based upon the individual goods and services sold to each individual patient. (See Section II of Memorandum In Support of Plaintiff's Motion for Summary Judgment and Permanent Injunction. It being undisputed that the foundations' member doctors have combined and agreed to sell their individual goods and services on an individual basis at agreed-upon prices, *per se* analysis is mandated in this case.

II.

THE AUTHORITIES CITED BY THIS COURT DO NOT JUSTIFY FINDING A TREND TOWARDS RULE OF REASON ANALYSIS IN PRICE-FIXING CASES. INDEED, THE VERY AUTHORITIES CITED AND OTHER EXPLICIT SUPREME COURT DECISIONS WHICH WERE OVERLOOKED EXPRESSLY ESTABLISH THAT THERE IS NO SUCH TREND.

In concluding that "a recent antitrust trend appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust laws, Memorandum and Order of June 5, 1979, at 7, this Court cited only three authorities. *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 97 S.Ct. 2549 (1977); *General Glass Co., Inc. v. Globe Glass and Trim Co.*, 1978-2 CCH Trade Cas. ¶ 62,231 (N.D. Ill. 1978); Handler, *Changing Trends in Antitrust Doctrine: An Unprecedented Supreme Court Term—1977*, 77 Colum. L. Rev. 979 (1977). Whatever they may say about other antitrust violations, those three authorities do not show a trend away from *per se* analysis in horizontal price-fixing cases. Indeed, the very authorities cited by this Court as

well as an abundance of other recent decisions[4] which were unfortunately overlooked in the Memorandum and Order of June 5, 1979 expressly recognize that the *per se* rule is alive and well in horizontal price-fixing cases.

Until this Court's decision, only the decision of the Federal District Court for the Northern District of Illinois in *General Glass* supported the proposition that there was a trend away from *per se* analysis in horizontal price-fixing cases. The so-called trend perceived in *General Glass*, however, was at most an unfortunate and ill-considered *obiter dictum*[5] and that solitary district court opinion can hardly be said to be a trend by itself since the court there seriously

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[4] *E.g., Broadcast Music, Inc. v. Columbia Braodcasting Co.*, 99 S.Ct. 1551, 1556 (1979); *United States v. United States Gypsum Co.*, 98 S.Ct. 2864, 2873, 2878, 2884 and nn.13, 22 (1978); *Cernuto, Inc. v. United Cabinet Corp.*, 1979-1 CCH Trade Cas. ¶ 62,509, at 76,964 (3d Cir. 1979); *United States v. Gillen*, 1979-1 CCH Trade Cas. ¶ 62,627, at 77,577-77, 579 (3d Cir. 1979); (M.D. Pa.); *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471, 486-87 (N.D. Ga. 1979); *United States v. Nu-Phonics, Inc.*, 433 F. Supp. 1006, 1011 (D. Mich. 1977), *final judgment*, 1979, 1 CCH Trade Cas. ¶ 62,252.

[5] Relying on the *General Glass* opinion as a prognosticator of trends in the antitrust law seems ill-advised for another reason. The actual holding in *General Glass* (as opposed to the dictum concerning a trend away from *per se* analysis), concerned the scope of the McCarran-Ferguson exception and *General Glass* specifically declined to follow the Fifth Circuit opinion in *Royal Drug Co. v. Group Life & Health Insurance Co.*, 556 F.2d 1375 (5th Cir. 1977), which was subsequently affirmed by the Supreme Court of the United States. 99 S.Ct. 1067 (1979). If *General Glass* is to be relied upon for its gift of prophecy, it must be done with the knowledge that it has been proven to be a false prophet.

misread the authorities it cited for finding such a trend.[6]

A 1977 law review article by Milton Handler was cited in *General Glass* and was extensively quoted by this Court in support of the idea that there is a trend away from *per se* analysis in price-fixing cases. Yet the Handler article not only does not say that there is such a trend, it expressly reaffirms the principle that the *per se* rule applies to horizontal price-fixing conspiracies. The passage from the Handler article quoted by this Court dealt solely with the Supreme Court's 1977 decision in the *Sylvania* case and the legal standard which is applicable to the vertically-imposed territorial restraints involved there. In the article's conclusion, Handler expressly acknowledges the limited impact of *Sylvania* on the traditional *per se* violations: *"Except for the traditional per se interdictions* and with the likelihood that there will be few additions in the future, it would seem

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[6] *General Glass* based this supposed trend upon only three authorities which it mentioned but briefly in a footnote without any discussion or analysis:

> This conclusion is supported by the recent decisions of the Supreme Court in *Illinois Brick v. Illinois*, 431 U.S. 720, 97 S.Ct. 2061 (1977) and in *Continental T.V. v. GTE Sylvania*, 433 U.S. 36, 97 S.Ct. 2549 (1977). In these decisions the *per se* approach of determining § 1 Sherman Act antitrust violations, *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365, 87 S.Ct. 1856 (1967), was disapproved in favor of the "rule of reason" approach.
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> For a through and compelling discussion in favor of the rule of reason approach to antitrust violations, see, *Handler, Changing Trends in Antitrust Doctrine: An Unprecedented Supreme Court Term—1977*, 77 Col. L. Rev. 979 (Nov. 1977).

1978-2 CCH Trade Cases at 74,490 n.3.

Illinois Brick Co. v. Illinois was the only authority for this supposed trend away from *per se* analysis cited by *General Glass* and not by this Court. This Court was correct in not citing *Illinois Brick* because that case dealt only with the question who is entitled to recover under section 4 of the Clayton Act, 15 U.S.C. § 15, and did not consider the legality of conduct under section 1 of the Sherman Act, 15 U.S.C. § 1, did it even mention the phrases "rule of reason" and *"per se* rule." As appears from the text above, *General Glass* misconstrued the other authorities it cited as badly as it did *Illinois Brick*.

that ... the need for a factual demonstration of illegality ... is now the prevailing doctrine." 7 Colum. L. Rev. at 1038 (emphasis added). And, in another passage of his article also unfortunately overlooked by this Court, Handler puts price-fixing violations squarely within the traditional *per se* rule: "The traditional *per se* violations of section 1 are agreements fixing prices, dividing territories, curbing production, or effectuating a boycott." *Id.* at 993. It was error, then, for this Court to rely on Handler's article to support the theory that the *per se* rule is no longer applicable to horizontal price-fixing agreements[7] because his article expressly recognizes the continued applicability of the *per se* rule in such cases.

Although he is a leading member of the antitrust defense bar, Handler is still only a commentator expressing his own views and interpretations of the Supreme Court decision in *Sylvania*. The opinions in *General Glass* and by this Court that the *per se* rule has been eroded in horizontal price-fixing cases likewise trace back to their interpretations of the *Sylvania* decision. Since the *Sylvania* decision therefore becomes the fountainhead for the notion that the *per se* rule no longer applies to price-fixing cases, it is appropriate to return to *Sylvania* to see precisely what the Supreme Court actually said there.

In *Sylvania*, the Supreme Court reexamined its earlier ruling in *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365, 379, 380, 87 S.Ct. 1856, 1865, 1866 (1967), where it had held that vertically-imposed territorial restraints were *per se* unlawful "after the manufacturer has parted with dominion over [an article]," but that such restraints were to be judged under the broader rule of reason when "the manufacturer retains title, dominion, and risk with respect to the product and the position and function of the dealer in ques-

[7] *Cf., Consolidated Express, Inc. v. New York Shipping Ass'n, Inc.*, 1979-1 CCH Trade Cas. ¶ 62,589, at 77,403-77, 404 (D.N.J. 1979) (rejecting defense argument for Rule of Reason analysis based on Milton Handler article and applying *per se* analysis to group boycott.)

tion is, in fact, indistinguishable from those of an agent or salesman of the manufacturer." After noting the *Schwinn* was a "sudden change" from earlier precedent, 433 U.S. at 51, 97 S.Ct. at 25, 58, and reasoning that the distinction "between sale and nonsale transactions is not sufficient to justify the application of a *per se* rule in one situation and a rule of reason in the other," *id.* at 57, the Supreme Court overruled *Schwinn's per se* prohibition of vertically-imposed territorial restraints.

Throughout its opinion, however, the *Sylvania* Court was careful to emphasize that it was concerned "only with non-price vertical restrictions." *Id.* at 51, 97 S.Ct. at 2558 n.18 (emphasis added). Indeed, Handler's view of the continued vitality of the *per se* interdiction against horizontal price-fixing is expressly supported and the contrary view in *General Glass* and in this Court's opinion is explicitly rejected in the *Sylvania* decision itself where the Supreme Court emphasized that:

> *The per se illegality of price restrictions has been established firmly for many years and involves significantly different questions of analysis and policy.* As Mr. Justice White notes, some commentators have argued that the manufacturer's motivation for imposing vertical price restrictions may be the same as for nonprice restrictions. There are, however, significant differences that could easily justify different treatment. In his concurring opinion in *White Motor Co. v. United States*, Mr. Justice Brennan noted that, unlike nonprice restrictions, "[r]esale price maintenance is not designed to, but almost invariably does in fact, reduce price competition not only *among* sellers of the affected product, but quite as much *between* that product and competing brands." Professor Posner also recognized that "industry-wide resale price maintenance might facilitate cartelizing." Furthermore, Congress recently has expressed its approval of a *per se* analysis of vertical price restrictions by repealing those provisions of the Miller-Tydings and McGuire Acts allowing fair trade pricing at the option of the

individual States. No similar expression of congressional intent exists for nonprice restrictions. *Id.* (emphasis added, citations omitted).

Apart from the dictum in *General Glass* on which this Court relied, plaintiff has not found a single case in which a trend away from *per se* analysis for horizontal price-fixing has been perceived. To the contrary, the Supreme Court as well as the lower federal courts, have consistently emphasized in opinions written after *Sylvania* that horizontal agreements to fix prices on individual goods or services are within the *per se* category. In *Professional Engineers*, decided a year after Sylvania, the Supreme Court affirmed the decisions of the district and circuit courts, which had held that a professional society's ban on solicitation by competitive bidding was unlawful *per se* under *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975). *United States v. National Society of Professional Engineers*, 404 F. Supp. 457 (D.D.C. 1975), *aff'd* F.2d 978 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679, 98 S.Ct. 1355. Although the Supreme Court found that the ethical rule against competitive bidding was "not price-fixing as such," 435 U.S. at 692, 98 S.Ct. at 1365, it emphasized that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." *Id.*

> Price is the "central nervous system of the economy," *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n.59, 60 S.Ct. 811, 845, 84 L.Ed. 1129, and *an agreement that "interfere[s] with the setting of price by free market forces" is illegal on its face. Id.*

Even in the brief period since *Professional Engineers* was decided, the Court has reiterated its intolerance of horizontal price-fixing on several occasions, most recently in *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 99 S.Ct. 1551 ("[The *per se*] rule is a valid and useful tool of antitrust policy and enforcement. And agreements among competitors to fix prices on their individual goods or services are among those concerted activities that the Court

has held to be within the *per se* category.") In *United States v. United States Gypsum Co.*, 98 S.Ct. 2864, 2878 n.22 (1978), the Court emphasized that the mere exchange of price information by competitors is a sufficient predicate for civil liability where there is proof of an anticompetitive effect. *See also United States v. Gillen*, 1979-1 CCH Trade Cas. ¶ 62,627, at 77,578-77,579 (3d Cir. 1979) (applying *per se* rule in criminal case).

The lower federal courts have also continued to apply the *per se* rule in horizontal price-fixing cases, as in *United States v. Nu-Phonics, Inc.*, 433 F. Supp. 1006, 1011 (D. Mich. 1977), in which the district court stated:

> Nobody would argue that price-fixing is not a *per se* violation of section 1 of the Sherman Act, and none of the defendants have [sic] taken that position. . . . No argument is more clearly an unreasonable restraint upon trade than an agreement among competitors to fix their prices, and such agreements have been *per se* violations of the Sherman Act since the early history of the Act. Id. (citations omitted.)

Another district court decision, *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471 (N.D. Ga. 1979), which involved collective rate coordination and publication by common carrier rate bureaus, reflects the current judicial trend in cases involving price restraints far more accurately than the dictim in *General Glass* which was relied upon in this Court's Memorandum and Order of June 5, 1979. That case involved the collective coordination and publication of rates by common carrier rate bureaus. Having determined that the challenged practice of collective rate coordination and publication through a rate bureau was not immune from the antitrust laws under the state action doctrine, the Noeer-Pennington doctrine or the First Amendment, the court ruled that those practices constituted *per se* violations of section 1 of the Sherman Act and entered summary judgment in favor of plaintiff.

> [T]he practice of collective rate publication easily fits the classic description of a "naked price restraint." Since *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 60 S.Ct. 811, 84 L.Ed. 1129 (1940), it has been established law that price-fixing among competitors is a *per se* violation of section 1 of the Sherman Act. Because the guiding principle behind all Sherman Act jurisprudence is the protection of competition, any arrangement whose purpose or effect is to inhibit price competition is illegal. Such an arrangement need not be outright cartelization, so long as it brings about the "raising, depressing, fixing, pegging, or stabilizing" of prices.
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> 467 F. Supp. at 486 (citations omitted).

Because the defendants in that case had coordinated the rates of their member carriers, the district court found that they had had the precise effect on prices which the Supreme Court has consistently condemned as *per se* illegal.

> Within the "zone of reasonableness" in which, free from regulatory interference, market forces would otherwise determine price, the defendants have displaced competition with concerted pricing decisions. In so doing, they violate the Sherman Act at its most sensitive spot. The defendants' practices of collective rate coordination and publication are *per se* violations of Section 1, subject to injunction by this court. *Id.* (Citations omitted.)

Whatever trend there may be in the legal standards applied to non-price restraints of trade, it is clear that horizontal price-fixing of individual goods or services remains *per se* unlawful.

III

HORIZONTAL PRICE AGREEMENTS AMONG COMPETITORS ARE UNIVERSALLY JUDGED UNDER THE *PER SE* RULE AND THIS COURT'S CONTRARY DECISION STANDS ALONE IN THE ANNALS OF ANTITRUST LAW

A. Horizontal Agreements To Fix Maximum Prices Are Appropriately Considered Unlawful Per Se

Although this Court's Memorandum and Order of June 5, 1979 acknowledges at one point that "[t]he *per se* rule has been applied to fixing maximum prices as well as minimum prices," Slip Op. at 6, *citing Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 71 S.Ct. 259 (1951), it nonetheless declines to follow this acknowledged authority from the Supreme Court of the United States, incongruously stating that "the two Supreme Court cases invalidating maximum price-fixing, *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., supra,* and *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), need not be read as establishing a *per se* rule." Memorandum and Order of June 5, 1979, at 8. The only authority cited by this Court for not following explicit and acknowledged authority from the Supreme Court of the United States is a recent law review article which not only fails to support this Court's conclusion, but which maintains in the strongest terms that the maximum fee schedules adopted by foundations for medical care are and should be deemed unlawful *per se.* Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act,* 1978 Duke L.J. 645, 680-84, 691-94 (hereinafter Kallstrom, *Fee Schedules").*

The two Supreme Court cases invalidating maximum price-fixing, *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons,* 340 U.S. 211, 71 S.Ct. 259, and *Albrecht v. Herald Company,* 390 U.S. 145, 88 S.Ct. 869, clearly indicated that the *per se* standard was just as applicable to maximum

price-fixing as to minimum price-fixing, and they have accordingly and consistently been cited by the federal courts as having established a *per se* rule.* In fact, plaintiff has found no case in which any federal judge—even in dissent—said that a horizontal agreement to fix maximum prices is not *per se* unlawful. In *Kiefer-Stewart*, the Court held that an agreement between competing liquor distillers on the maximum prices at which wholesalers would sell their products violated the Sherman Act. Reversing a circuit court decision to the contrary, the Court held that:

> The Court of Appeals erred in holding that an agreement among competitors to fix maximum resale prices of their products does not violate the Sherman Act. For such agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with

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* Among the cases which cite *Kiefer-Stewart* or *Albrecht* for a *per se* rule are the following:

White Motor Co. v. United States, 372 U.S. 255, 260, 83 S.Ct. 696, 700 (1963); *United States v. Parke, Davis and Company*, 362 U.S. 29, 47,80 S.Ct. 503, 513 (1960); *Schwegemann Bros. v. Calvert Distillers Corp.*, 341 U.S. 384, 386, 71 S.Ct. 745, 746 (1951); *Hardwick v. Nu-Way Oil Co., Inc.*, 589 F.2d 806, 808 (5th Cir. 1979); *United States v. National Society of Professional Engineers*, 555 F.2d 978, 980-983, n.2 (D.C. Cir. 1977), *aff'd*, 98 S.Ct. 1355 (1978); *Pitchford v. Pepi, Inc.*, 531 F.2d 92, 98 n.9 (3d Cir. 1976); *Bowen v. New York News, Inc.*, 522 F.2d 1242, 1248 (2d Cir. 1975); *Greene v. General Foods Corp.*, 517 F.2d 635, 653-54 (5th Cir. 1975); *De Filippo v. Ford Motor Co.*, 515 F.2d 1313, 1317 (3d Cir. 1975); *Copper Liquor Inc. v. Adolph Coors Co.*, 506 F.2d 934, 946 (5th Cir. 1975); *E.A. McQuade Tours, Inc. v. Consolidated Air Tour Manual Committee*, 467 F.2d 178, 187 (5th Cir. 1972); *Janel Sales Corp. v. Lanvin Parfums, Inc.*, 396 F.2d 398, 402 (2d Cir. 1968); *Giradi v. Gates Rubber Company Sales Division, Inc.*, 325 F.2d 196, 199 n.5 (9th Cir. 1963); *Plymouth Dealers' Ass'n of Northern California v. United States*, 279 F.2d 128, 132 (9th Cir. 1960); *Virginia Excelsior Mills v. Federal Trade Commission*, 256 F.2d 538, 540-41 (4th Cir. 1958); *Lloyd v. United Liquors Corp.*, 203 F.2d 789, 795-96 (6th Cir. 1953); *Knutson v. Daily Review, Inc.*, 468 F. Supp. 226, 231 n.7 (1979); *Carr Electronics Corp. v. Sony Corp. of America*, 1979-1 CCH Trade Cas. ¶ 62, 540, at 77,140 (N.D. Cal.);

their own judgment. We reaffirm what we said in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223, 60 S.Ct. 811, 844, 84 L.Ed. 1129: "Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*." 340 U.S. at 213, 71 S.Ct. at 260.

In *Albrecht*, the Court again reversed the decision of the circuit court, this time ruling that a combination between a newspaper and another company to enforce maximum retail prices for the newspaper's carriers was in violation of the Sherman Act. After restating and reaffirming the holding of *Kiefer - Stewart*, the Court ruled in no uncertain terms

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[a] *Suburban Beverages, Inc. v. Pabst Brewing Co.*, 462 F. Supp. 1301, 1306 (E.D. Wis. 1978); *DuPont Glore Forgan, Inc. v. Am. Tel. & Tel. Co.*, 437 F. Supp. 1104, 1113 (S.D.N.Y. 1977); *Crown Central Petroleum Corp. v. Brice*, 427 F. Supp. 638, 640 (E.D. Va. 1977); *Aaron E. Levine & Co., Inc. v. Calkraft Paper Co.* 29 F. Supp. 1039, 1046 (E.D. Mich. 1976); *V & L Cicione, Inc. v. C. Schmidt & Sons, Inc.*, 403 F. Supp. 643, 655 (E.D. Pa. 1975); *Call Carl, Inc. v. B P Oil Corp.*, 403 F. Supp. 568, 573-74 (D.Md. 1975); *Phillips v. Crown Central Petroleum Corp.*, 395 F. Supp. 735, 760 (D. Md. 1975); *Evans v. S.S. Kresge Co.*, 394 F. Supp. 817, 847 (W.D. Pa. 1975); *Capitol Temporaries of Hartford v. Olsten Corp.*, 383 F. Supp. 902, 909-910 (D. Conn. 1974); *Jacoby v. Bache & Co., Inc.*, 377 F. Supp. 86, 96 (S.D.N.Y. 1974); *Sunny Hill Farms Dairy Co. v. Kraftco Corp.*, 381 F. Supp. 845, 853 n.8 (E.D. Mo. 1974); *Schnappes Shop, Inc. v. H.W. Wright & Co., Ltd.*, 377 F. Supp. 570, 581-82 (E. Md. 1973); *United States v. General Electric Co.*, 385 F. Supp. 731, 734 (S.D.N.Y. 1973); *Vandervelde v. Put and Call Brokers and Dealers Ass'n*, 344 F. Supp. 118, 134, 136-37 (S.D.N.Y. 1972); *Pearl Brewing Co. v. Anheuser-Busch, Inc.*, 339 F. Supp. 945, 951-52 (S.D. Tex. 1972); *United States v. Uniroyal, Inc.*, 300 F. Supp. 84, 88-89 (S.D.N.Y. 1969); *Stanton v. Texas, Inc.*, 289 F. Supp. 884, 889 (D.R.I. 1968); *United States v. Serta Associates, Inc.*, 296 F. Supp. 1121, 1123 (N.D. Ill. 1969); *Checker Motors Corp. v. Chrysler Corp.*, 283 F. Supp. 876, 882 (S.D.N.Y. 1968); *Wurzberg Brothers, Inc. v. Head Ski Co.*, 276 F. Supp. 142, 145-46 (E.D. Tenn. 1967); *Bolick-Gillman Co. v. Continental Baking Co.*, 206 F. Supp. 151, 157 (N.D. Ohio 1961).

that maximum price-fixing is "*without more*, an illegal restraint of trade under § 1 of the Sherman Act." 390 U.S. at 153, 88 S.Ct. at 873 (emphasis added).

> *We think Kiefer-Stewart was correctly decided and we adhere to it.* Maximum and minimum price-fixing may have different consequences in many situations. *But schemes to fix maximum prices, by substituting the perhaps erroneous judgment of a seller for the forces of the competitive market, may severely intrude upon the ability of buyers to compete and survive in that market.* Competition even in a single product, is not cast in a single mold. Maximum prices may be fixed too low for the dealer to furnish services essential to the value which goods have for the consumer or to furnish services and conveniences which consumers desire and for which they are willing to pay. Maximum price-fixing may channel distribution through a few large or specifically advantaged dealers who otherwise would be subject to significant nonprice competition. *Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasingly likely as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all the attributes of an arrangement fixing minimum prices.* It is our view, therefore, that the combination formed by the respondent in this case to force petitioner to maintain a specified price for the resale of the newspapers which he had purchased from respondent constituted, without more, an illegal restraint of trade under § 1 of the Sherman Act. *Id.* (emphasis added).

The Court of appeals for the Ninth Circuit has also held an agreement among competitors on a maximum or "list" price to be a *per se* violation of the Sherman Act. *Plymouth Dealers's Ass'n of Northern California v. United States*, 279 F.2d 128 (9th Cir. 1960), involved the publication and circulation by an automobile dealers' association of a price schedule which provided a "list price" to be used as an agreed-upon starting point in bargaining with customers.

Although the "list price" had not been precisely followed in most instances, the Ninth Circuit held that the price schedule was *per se* unlawful, since it established "one boundary of 'the range within which * * * sales would be made.' " 279 F.2d at 134, *quoting Socony-Vacuum Oil Co.*, 310 U.S. at 150, 222, 60 S.Ct. at 811, 844.

Similarly, in *Vandervelde v. Put and Call Brokers and Dealers Ass'n*, 344 F. Supp. 118 (S.D.N.Y. 1972), a brokers' association rule requiring that a commodity offered for sale by any member broker be sold to another member broker at a discount from the authorized price was held to be *per se* unlawful. Reasoning that "[w]hat the rule here requires is that a maximum resale price be charged a certain class of buyers," 344 F. Supp. at 137, the district court held that the rule amounted to maximum price-fixing having significant anticompetitive effects. *See* 344 F. Supp. at 133-139.

> § 23 involves the imposition of a restriction upon the freedom of the individual members of the Association to set and abide by their own price in the limited marketplace in which they operate. Such restrictions are at the heart of the Sherman Act's prohibitions. *Id.* at 138.

Unlike *Kiefer-Stewart* and *Albrecht*, but similarly to *Plymouth Dealers Association* and *Vandervelde*, this case does not involve a vertical price restraint or resale price maintenance, but a direct horizontal agreement among sellers on the maximum prices to be paid for their services. Indeed, the facts of the present case are far more egregious than the facts of *Albrecht* or *Kiefer-Stewart*. A purely vertical restraint on prices might have a deflationary effect because the producer's incentive would be to increase volume by reducing the resale price, but the raison d'etre of horizontal price agreements is to maximize profits. As Judge Coffin concluded in a thoughtful commentary on vertical and horizontal maximum price-fixing, "an identical or parallel system of maximum prices between [competitors] is likely to become a system of minimum prices." *Quinn v. Mobil Oil Company*, 375 F.2d 273, 277-78

(1st Cir. 1967) (Coffin, J., concurring). Studies have proven what the Supreme Court and Judge Coffin surmised. When doctors know the maximum prices allowed for their services, they tend to charge at those maximum levels. *(See, e.g.,* Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans,* at 142 (April 1978), citing Review of Administration of Dependents' Medical Care Program by the Department of the Army, Rept. to the Congress by the Comptroller General (General Accounting Office) 12-27 (May 1961) (hereinafter FTC Staff Report). It is hardly surprising, then, that when maximum price levels are not only communicated to doctors but are adopted by majority vote of a doctors' cartel, 85 to 95 percent of the cartel members charge at or above the agreed-upon rates. (See Statement of Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction (hereinafter "Statement of Facts") precisely as Justice White predicted in *Albrecht*, the fee schedules adopted by the foundations' member doctors substitute the collective decision of a sellers' cartel for the forces of a competitive market, and severely intrude upon the ability of third party payors to negotiate at arm's length on the prices to be paid for doctors' services.

Thus, commentators have urged that foundations for medical care which adopt maximum fee schedules by horizontal agreement "should be recognized as part of a profit-maximizing strategy of a coalition of monopolists" and the authority of *Albrecht* and *Kiefer-Stewart* be "appropriately invoked to curb private price regulation by a cartel." Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 377-378 (hereinafter Havighurst, *Professional Restraints.)* Indeed, the single authority on which this Court relied in disregarding the Supreme Court's judgment in *Albrecht* and *Kiefer-Stewart* strenuously advocates the application of the *per se* rule to the horizontal maximum price-fixing of foundations for

medical care. Kallstrom, *Fee Schedules, supra.* The recommendation of that author is, in fact, the very objective of the State of Arizona in prosecuting this lawsuit, that is, that "[f]ee schedules that are initiated as the independent effort of insurers ... and are negotiated with doctors who make their decisions individually, should be encouraged[,]" *id.* at 680, but fee schedules adopted by a horizontal combination of doctors and dictated to insurers in cartel fashion should be held *per se* unlawful. Id.

In the passage relied upon by this Court, Kallstrom urges that *Kiefer-Stewart* and *Albrecht* should not be read to invalidate provider agreements between individual insurers and individual doctors.[9] Unfortunately, the Court overlooked the author's analysis of the very different type of price agreement which is at issue in this case. In Section V of the Kallstrom article, which is pointedly entitled "Separating Fee Schedules from Provider Control: The Crucial Limitation," the author explains that:

> The governing rule that emerges from the prepaid drug and legal service plans is that the antitrust laws basically support such plans except to the extent that they camouflage or embody horizontal agreements by competing providers of services. Physicians may not agree as a group on an acceptable fee arrangement or suggest that arrangement to an insurer. Physicians may not combine and collectively bargain for favorable fees. A fee schedule would be illegal if it received the

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[9] Kallstrom's concerns in that regard might instead be directed to the question whether such an arrangement constitutes a "conspiracy" within the meaning of the Sherman Act. In *Group Life & Health Ins. Co. v. Royal Drug Co.*, 99 S.Ct. 1067 (1979), the Department of Justice, appearing as an amicus curiae, took the position that the Pharmacy Agreements in question there probably did not violate the antitrust laws. See 99 S.Ct. at 1072 n.5. The Arizona attorney general also maintains the position that a reimbursement schedule which is initiated as the independent effort of a third party payor and negotiated with individual doctors on an independent basis is not unlawful. This issue will presumably be determined in the *Royal Drug* litigation on remand to the district court, but it is not an issue in this lawsuit.

imprimatur of a medical association or if a medical association served as an "advisor" to an insurer in its compilation. *Id.* at 678-79.

Kallstrom then recommends as "an acceptable bright line guide" for policing fee schedules that:

> Fee schedules, to pass muster under the antitrust laws, must be unilaterally initiated by insurers and offered to individual providers for their acceptance or rejection. *Id.* at 678-79. Fee schedules that are developed with any involvement by a medical association of any kind should be condemned *per se*. Fee schedules that are initiated as the independent effort of insurers, however, and are negotiated with doctors who make their decisions individually, should be encouraged. This kind of arrangement should be approved unless there is affirmative proof that it has been abused—that it is a sham that hides an agreement among doctors, perpetrated either by a deliberate combination to fix prices or through the more subtle pressures of a medical association. Unfortunately, the fee schedule efforts that have been the most prevalent in the medical profession to date fall on the impermissible side of this antitrust analysis. *Id.* at 679-680.

In identifying foundations for medical care as "[p]erhaps the most blatant examples of concerted provider involvement in fee setting arrangements," *id.* at 680, Kallstrom warned against their anticompetitive impact.

> One should note the crucial distinction between the efforts of FMCs (foundations for medical care), which are run by organized medicine, and the cost-containment measures suggested in this Article. Because of the medical society sponsorship of FMCs, their maximum price control takes on a horizontal aspect not present in insurer-initiated plans. The price-determining activities of the foundations go far beyond the limits indicated by the data dissemination cases. Structurally, FMCs closely resemble the proposed bar-sponsored prepaid legal insurance plans to which the Justice Department has objected on Sherman Act

> grounds. It should come as no surprise then that FMC-type provider price-control activities, especially some of the Blue plans, are being attacked as anticompetitive. Professor Havighurst has forcefully argued that the very purpose of FMCs is to set an entry-discouraging price that will preclude other forms of third party competition and thus that a *per se* rule would be appropriate to condemn them.[10]

Clearly, this Court's decision *not* to apply a *per se* rule to this "blatant example of concerted provider involvement in fee setting arrangements" cannot be supported by the single commentator on whom the Court relied.

B. Because Uniform Pricing Is Their Purpose and Result, The Fee Schedules Adopted By The Foundations' Member Doctors Are Clearly Within The Per Se Category.

The By-Laws of the defendant foundations expressly provide for the adoption of "uniform fee schedules" by majority vote of their member doctors, and the record clearly establishes that those fee schedules—only lately referred to as "maximum" rather than "uniform" fee schedules—have had the purpose and effect of encouraging price uniformity among doctors. As is more fully described in the Memorandum in Support of Plaintiff's Motion for Summary Judgment and Permanent Injunction, it is undisputed that the defendants have repeatedly conducted preliminary surveys and meetings of their member doctors and various specialty societies of doctors in order to be sure that the fee schedules proposed to their membership represented the majority of doctors' charges. Also undisputed is the fact

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[10] *See* Havighurst, [*Health Maintenance Organizations and the Market for Health Services*, 35 Law & Contemp. Prob. 716,] 769-77 [(1970) *cf.* Egdahl, [*Foundations for Medical Care*, 283 New England J. Med. 491,] at 496 [(1973)] (VJC operations could destroy the viability of third party issuers and independent intermediaries in the health care delivery system). *But see* Comment, [*Private Physician Unions: Federal Antitrust and Labor Law Implications*, 20 U.C.L.A.L Rev. 983,] at 1009-10 [(1973)].

that both current and future prices were discussed and agreed upon in the polls and meetings which were instigated by the defendants. Defendants admit that the results of their preliminary price surveys and price agreements were used in preparing the fee schedules which were proposed to their membership for adoption, and that the membership was often advised before they voted on the proposed fee schedules that the proposals represented a "consensus" on the fees charged by a majority of doctors in the community or that they had already been adopted by the members of a sister foundation. The record clearly establishes, moreover, that the fee schedules which defendants proposed to their members were set above the average or median level of doctors' fees at the time the membership ballot was taken and that after the proposed fee increases were approved by the defendants' member doctors, 85 to 95 percent of those doctors billed at or above the agreed-upon rates. It is, then, a matter of record that defendants' price agreements have produced substantial uniformity in the prices charged by the defendants' member doctors, who have represented a significant portion of the fee-for-service doctors in their communities.

Because the defendants' price agreements unquestionably had the purpose and effect of encouraging uniform pricing by doctors, they are clearly within the *per se* category. Since the earliest interpretations of the Sherman Act by the Supreme Court, agreements to fix uniform prices have consistently been held *per se* unlawful. *E.g., United States v. Trenton Potteries Co.*, 273 U.S. 392, 47 S.Ct. 377, (1927).

> Beginning with *United States v. Trans-Missouri Freight Association, supra*, and *United States v. Joint Traffic Association*, 171 U.S. 505, 19 S.Ct. 25, 43 L.Ed. 259, where agreements for establishing reasonable and uniform freight rates by competing lines of railroads were held unlawful, it has since often been decided and always assumed that uniform price-fixing by those controlling in any substantial manner a trade or busi-

> ness in interstate commerce is prohibited by the Sherman Law, despite the reasonableness of the particular prices agreed upon. *Id.* at 398, 47 S.Ct. at 380

On the few occasions when lower federal courts have spared horizontal price-fixing agreements from the application of the *per se* rule, they have been reversed by the Supreme Court. *E.g., Goldfarb v. Virginia State Bar*, 497 F.2d 1 (4th Cir. 1974), *rev'd*, 421 U.S. 773, 95 S.Ct. 2004 (1975). In *United States v. McKesson and Robbins, Inc.*, 351 U.S. 305, 76 S.Ct. 937 (1956), for example, the district court ruled that "fair trade price-fixing by a producer-wholesaler was not *per se* illegal under the Sherman Act," even though the price-fixing agreements with independent wholesalers at the issue in that case were horizontal in character. 351 U.S. at 309, 76 S.Ct. at 940. Noting that the Miller-Tydings Act did not apply to horizontal price agreements, the Supreme Court ruled that "[t]he District Court was plainly in error in attempting to create a category of agreements which are outside the exemption of those Acts but which should nevertheless be spared from application of the *per se* rule. 351 U.S. at 311, 76 S.Ct. at 941. As the Court stated in *United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485, 489, 79 S.Ct. 711, 714 (1950):

> Price-fixing is *per se* an unreasonable restraint of trade. *It is not for the courts to determine whether in particular settings price-fixing serves an honorable or worthy end. An agreement, shown either by adherence to a price schedule or by proof of consensual action fixing the uniform or minimum price, is itself illegal under the Sherman Act, no matter what end it was designed to serve.* That is the teaching of an unbroken line of decisions.

Given that unbroken line of decisions and the broad language and purpose of the antitrust laws, the federal courts have strongly disfavored exceptions to the established stan-

dards for antitrust liability. *See, e.g., Reiter v. Sonotone Corp.*, 47 U.S.L.W. 4672 (Sup. Ct., June 11, 1979); *Group Life and Health Ins. Co. v. Royal Drug Co.*, 99 S.Ct. 1067 (1979). As the district court commented in *Goldfarb:*

> The scope of the statutory language in the Sherman Act is so expansive that courts have been reluctant to find exceptions. The language explicitly states that "every contract, combination or conspiracy which restrains commerce among several states is unlawful." Illustrative of this reluctance is the refusal to extend baseball's exempt status to other professional sports. *See Radovich v. National Football League*, 352 U.S. 445 (1957); *United States v. International Boxing Club*, 348 U.S. 236 (1955). The fact that specific exemptions are clearly delineated suggests that ambiguities should be resolved in favor of inclusion. This is especially true where price-fixing is involved since it has been declared both pernicious and lacking in any redeeming social value. 355 F. Supp. 491, 493 (citations omitted).

Recognizing and applying the established *per se* rule for horizontal price-fixing, the Court of Appeals for the Ninth Circuit has held it *per se* unlawful for a "uniform list price," *Plymouth Dealers Ass'n of Northern California v. United States*, 279 F.2d at 133, or a published but voluntary fee schedule, *Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d at 379, 385-392 (9th Cir. 1962), *cert. denied*, 371 U.S. 862, 83 S.Ct. 119 (1962), to be produced by an association of competitors.

In this case, as in *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah 1962), *aff'd*, 371 U.S. 24, 83 S.Ct. 119 (1962), clear evidence

> of an established purpose, policy and project of the defendant Association[s], and stipulated [admitted] facts and exhibits that are clearly admissible as acts and declarations in furtherance of the objectives of the Association[s], leave no room for doubt that the officers and directors, with the intent of establishing

> uniform prices ... to the extent of their ability, adopted a pricing schedule and successive revisions, distributed them to members [and non-members] throughout the State and urged and induced the members to use the schedule for the pricing of prescription drugs. 201 F. Supp. at 34. *Accord, Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d 379.

Under these circumstances, this case is clearly governed by *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975). In *Goldfarb*, the district court followed the authority of the Supreme Court and the Court of Appeals for the Ninth Circuit in holding that a minimum fee schedule for legal services was a *per se* violation of section 1 of the Sherman Act.

> This type of price-fixing has been held under other circumstances to be repugnant to the philosophy of the Sherman Act. *Plymouth Dealers Ass'n v. United States*, 279 F.2d 128 (9th Cir. 1960). It is contrary to the spirit of competition which sustains a free enterprise system in that it prevents competitors from using their own judgment in determing the value of their own services. *Keifer-Stewart Co. v. Seagram and Sons*, 340 U.S. 211, 213 (1951) ... [A] defendant's liability under the Sherman Act depends not on actual adherence to the schedule but rather on the mere existence of an agreement which restricts competition by price-fixing. United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940); *Plymouth Dealers' Ass'n v. United States, supra.* 355 F. Supp. at 493-94.

The Court of Appeals for the Fourth Circuit reversed the district court's holding of liability, 497 F.2d 1 (4th Cir. 1973), but was in turn reversed by the Supreme Court. 421 U.S. 773 at 793, 95 S.Ct. and 2016. Emphasizing that "the price information disseminated [had] not concern[ed] past standards, but rather minimum fees to be charged in future transactions, and [that] those minimum rates [had been] increased over time[,]" 421 U.S. at 781, 95 S.Ct. at 2010, the

Supreme Court held that "here a naked agreement was clearly shown, and the effect on prices is plain." 421 U.S. at 782, 95 S.Ct. at 2010.

Commentators have recommended that the compilation and updating of relative value schedules by doctors' associations should be deemed *per se* unlawful even in the absence of agreements on the conversion factors to be used with those relative value schedules, because the maintenance and use of agreed-upon realtive value schedules is sufficient by itself to produce price uniformity. As explained by Kallstrom,

> The problems arise because price information activities of trade associations tend, whatever their ostensible purpose, to promote price uniformity. Due to the central and commanding market position occupied by a medical society, competing value scales are discouraged and providers are exhorted by the social pressures of the profession to design charges in accordance with the society's value schedule. The compilation and presentation of these schedules at medical society meetings facilitates the stabilization of prices because a provider can pigeonhole his charge schedule by mentioning a couple of past charges or by referring to his conversion factor and because an upward adjustment in the value of any service would result in an across-the-board increase in its price. . . .
>
> The compilation of relative value data by medical societies offends the Sherman Act because it requires the exchange of specific price information among competitors and tends to stabilize the prices of medical care in the affected community. Little would be lost and much might be gained by forbidding this activity as *per se* illegal under the Sherman Act. Providers will have to make charges with less sure knowledge of the price structures utilized by other providers, but this fact of life will improve competition, not defeat it. The sincerity and accuracy of some professionally designed relative value studies would be sacrificed, but equally reliable schedules can be drafted by competing insur-

ers engaged in arm's length bargaining with providers of care. Since no exigency appears which can justify professional participation in preparing and promoting relative value schedules, a rule condemning it seems appropriate. Kallstrom, *Fee Schedules*, supra at 693-94.

In this case there is a clear record of concerted agreements not just on the relative value schedules to be used by doctors, but on the dollar conversion factors as well. Moreover, it is not necessary for this Court to presume that price uniformity results from the defendants' challenged price agreements; the defendants have admitted that overwhelming price uniformity has occurred.[11] On this record the *per se* rule is clearly applicable.

IV.

THE *PER SE* RULE IS FULLY APPLICABLE TO COMMERCIAL HORIZONTAL AGREEMENTS AMONG PROFESSIONALS FIXING OR STABILIZING PRICES

In its Memorandum and Order of June 5, 1979, at 8-12, this Court concluded that the challenged conduct in the instant case should not be analyzed under the *per se* rule because that conduct involved a "profession" rather than a "commercial business." Plaintiff respectfully submits that under the prevailing case law the correct predicate for application of the *per se* rule in this case is not whether the defendant is a "profession," or a "commercial business" but

[11] In *Goldfarb*, the Supreme Court deplored the fact that the minimum fee schedule had created a market characterized by such price uniformity that "consumers could not turn to alternative sources for the necessary service." 421 U.S. at 782, 95 S.Ct. at 2010. Here the evidence shows that 85 to 95 percent of defendants' members use the foundation fee schedule as a price floor. Whatever the hardship borne by the consumers *who* sought legal services in connection with a real estate transaction in *Goldfarb*, it could not be greater than that of the Arizona citizen who needs medical assistance and must seek in that time of need the one doctor in 20 who might charge less than the agreed-upon fee adopted by the foundations' members.

whether the conduct at issue is the commercial business of a profession. The distinction between the commercial conduct of professionals, which is appropriately subject to the *per se* standard, and the non-commercial aspects of the professions which are more appropriately analyzed under the Rule of Reason, has been applied by the federal courts and recommended by the commentators, including those cited by this Court.

A comprehensive study of the application of the antitrust laws to the so-called "learned professions" is found in *United States v. Oregon State Bar*, 385 F. Supp. 507, 513-17 (D. Ore. 1974). Determining that the Supreme Court had left open "the question whether there is a 'learned profession' exemption to the Sherman Act," the district court in that case reviewed and analyzed the existing body of case law on that question and concluded that there was no "learned profession exemption." 385 F. Supp. at 515-16. It being the province of Congress rather than the courts to create exemptions from the Sherman Act, the court stated, "[i]t is not for this court to create a new exemption to the Sherman Act for so-called 'learned professions.'" 385 F. Supp. at 516. The court emphasized that an exemption based on professional status was particularly inappropriate where the conduct at issue was price-fixing.

> [T]he argument for exempting price-fixing activities of a "learned profession" is significantly weaker than the argument for exemption of other professional activities. Price-fixing is a *per se* violation of the Sherman Act. 385 F. Supp. at 516 (citation omitted).

Noting that several cases had indicated "that a viable line might be drawn between the 'commercial and noncommercial' activities of a profession," *id.* (citations omitted) the court concluded that the fee schedules for legal services which were at issue in that case could not be granted an exemption from antitrust liability.

> [t]here is no more commercial element to the practice of law than the setting of fees. Thus, even the acceptance by this Court of the exemption of noncommercial professional activities from the Sherman Act would not save defendant's fee schedules. 385 F. Supp. at 517.

Indeed, the Court of Appeals for the Ninth Circuit had previously ruled in another case involving horizontal price-fixing that the professional status of pharmacists could not provide them an exemption from antitrust liability. *Northern California Pharmaceutical Ass'n v. United States*, 306 F. Supp. 379, (9th Cir. 1962). Denominating professional status as "utterly irrelevant in the *instant* case," *id.* at 384 (emphasis in original), the Ninth Circuit held that no antitrust exemption was available "in an area of 'entrepreneurial,' rather than professional activity." [A] *prima facie* case of an agreement to fix prices" having been presented, the Ninth Circuit held the pharmaceutical associations price-fixing conduct to be unlawful under the *per se* rule. 306 F.2d at 385. *Accord, United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. at 33-34.

As the district court of *Goldfarb* aptly noted, "fee setting is the least 'learned' part of [a] profession." 355 F. Supp. at 495.

> The Court has some question whether the adoption of a minimum fee schedule is itself "professional." It seems to the Court that there is a basic inconsistency between the lofty position that professional services, not commodities, are here involved and the position that a minimum fee schedule is proper. The former properly contemplates differences in abilities worth and energies expended of those rendering the services. Such differences are made as meaningless by a minimum fee schedule as they would be by a maximum fee schedule. Although there is as yet no evidence of this

> here, the minimum fee schedule does permit the charging, by an attorney, of more than the services are worth. Certainly fee setting is the least "learned" part of the profession. *Id.*

This rationale was vindicated by the Supreme Court, which, finding no Sherman Act exemption for a "profession," held the fee schedules in question to be unlawful. 421 U.S. at 788, 95 S.Ct. 2014.

In its Memorandum and Order of June 5, 1979, *Goldfarb* did note the possibility that

> [t]he public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. *Id.* at 788, 95 S.Ct. at 2013 n.17.

But whatever "public service aspect" of a profession might merit special judicial treatment, that special treatment is not appropriate in a case of horizontal price-fixing, for *that* was precisely the conduct which *Goldfarb* held unlawful.

The Supreme Court's opinion in *Professional Engineers* certainly does not support this Court's ruling that horizontal price-fixing may be exempted from the *per se* rule when the defendant in the case is somehow engaged in a profession."

In *Professional Engineers,* the defendant professional group attempted to read into *Goldfarb's* footnote 17 an exemption from *per se* analysis which would extend to its ethical rule against solicitation by competitive bidding. As the district court described it,

> Defendant claims to detect in the *Goldfarb* case, particularly Footnote 17, a directive that a profession's activities and code of ethics are to be judged not under the traditional *per se* doctrine but under the rule of reason. 404 F. Supp. at 460.

That reading of *Goldfarb* was rejected by the district court, which held the ban on competitive bidding to be a *per se* violation of section 1 of the Sherman Act. 404 F. Supp. at 461.

> The Court rejects defendant's contention for a number of reasons. First, such a construction would substantially undermine the *Goldfarb* Court's denial of a total or partial exemption from antitrust regulation for professions. Neither the nature of an occupation nor any alleged public service aspect provides sanctuary from the Sherman Act. *Goldfarb, supra,* 421 U.S. at 787, 95 S.Ct. 2004. Second, *Goldfarb* does not rest upon a rule of reason analysis. The Court found price-fixing activities and condemned them outright. Third, Footnote 17 apparently distinguishes between a profession's business aspect, and its valid self-regulatory "restraints," such as membership requirements or standards of conduct. Price-fixing, however, receives no privileged treatment when incorporated into a code of ethics. Fourth, the activities at issue here have a wide-ranging commercial impact and therefore are to be judged by normal antitrust standards applicable to business practices. Fifth, while NSPE claims that its ban on competitive bidding protects public safety and health, the Supreme Court in *Goldfarb* had before it and rejected similar arguments aimed at preventing "cheap but faulty work" by professionals. The age-old cry of ruinous competition, competitive evils, and even public benefit cannot justify price-fixing. As Justice Douglas stated in *United States v. Socony-Vacuum Oil Co., supra,* "Any combination which tampers with price structures is engaged in an unlawful activity." 310 U.S. at 221, 60 S.Ct. at 843. *Id.* (footnotes omitted.)

In an opinion written by Judge Leventhal, the Court of Appeals for the District of Columbia Circuit affirmed and adopted the district court's analysis.

> The district court correctly appraised the rule before it as one that at its core "tampers with the price structure," and is therefore illegal without regard to claimed or possible benefits. 555 F.2d at 984.

The Supreme Court granted certiorari "to decide whether the District Court should have considered the factual basis for the [society's] proffered justification [that the ethical rule in question had been adopted by members of a learned profession for the purpose of minimizing the risk that competition would produce inferior engineering work endangering the public safety]." 455 U.S. at 681, 98 S.Ct. at 1360. Stating that "the cautionary footnote in *Goldfarb*, 421 U.S. at 788-789, n.17, 95 S.Ct. at 2013, . . . cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions." the Supreme Court specifically distinguished "[e]thical norms [which] may serve to regulate and promote . . . competition, and thus fall within the Rule of Reason" from the complete ban on competitive bidding which was at issue in that case, 435 U.S. at 696, 98 S.Ct. at 1367, and affirmed the decision of the District of Columbia Circuit. Id. at 699, 98 S.Ct. at 1369.[12]

Thus, the required predicate for applying the Rule of Reason to professional restraints of trade is *not* "that a profession is involved," Memorandum and Order of June 5, 1979, at 9, but that the conduct at issue is an "ethical norm which may serve to regulate and promote . . . competition." Conversely, *per se* analysis is appropriate when the conduct

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[12] Even more recently, the Supreme Court indicated that doctors' control of the reimbursement schedules of thire party payros should not be granted any exemption from established anatitrust standards.

> [E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health are providers typically dominate [certain insurance plans.] Thus, there is little incentive on the part of [the insurer] to minimize costs, since it is in he interest of the providers to set fee schedules at the highest possible level. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 99 S.Ct. 1067, 1083-84 n.40 (1979).

at issue involves the "commercial business" of a profession and has been determined by the Supreme Court to fall within the *per se* category.

The application of the *per se* rule where "a profession is involved" was succinctly described in *Veizaga v. National Bd. for Respiratory Therapy*, 1977-1 CCH Trade Cas. ¶ 61,274, at 70,870 (N.D. Ill. 1977):

> Where professional organizations are alleged to have commited a *per se* offense, a two-step analysis is required. First, the court must determine whether the challenged activity is, by its nature and character, commercial. If the court should find that it is commercial, the professional organization may be liable for a *per se* offense. However, if the court should find the activity to be noncommercial, it should then apply a rule of reason analysis, using the factors outlined in *Board of Trade v. United States*, 246 U.S. 231 (1917). We believe that the second step is necessary to ensure that those professional activities, while noncommercial in their character, but unreasonable (in the antitrust sense) in their impact, are subject to the antitrust laws. This analysis satisfies the concern of the Court that professions should be subject to the antitrust laws but still be treated differently where the public service aspects of the professions are involved. *Id.*

Plaintiff respectfully submits that this standard, rather than one based on professional status alone, is required by the prevailing case law.

The Ninth Circuit's decision in *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir. 1977), is fully compatible with that standard. Although *Boddicker* preceded the Supreme Court's decision in *Professional Engineers*, the Ninth Circuit rejected the defendants' contention in that case that their challenged practice of conditioning membership in a local dental association on membership in a national dental association was exempt from antitrust scrutiny because it involved a "learned profession." Significantly, the practice in question was *not* a

direct restraint on price or any other commercial aspect of dentistry, but merely a rule setting the conditions for membership in local dental associations. Focusing on the nature of the conduct at issue, the court restated in different terms the rule set forth in *Veizaga*.

> As we interpret [the Supreme Court's opinon in *Goldbarb*], to survive a Sherman Act challenge a particular practice, rule, or regulation of a profession, whether rooted in tradition or the pronouncements of its organizations, must serve the purpose for which the profession exists, *viz.* to serve the public. Those which only suppress competition between practitioners will fail to survive the challenge. This interpretation permits a harmonization of the ends that both the professions and the Sherman Act serve. 549 F.2d at 632.

Where the conduct at issue is horizontal price-fixing, the professional status of the defendants can afford them no exception from *per se* analysis. *See, e.g., Ballard v. Blue Shield*, 543 F.2d 1075, 1079 (4th Cir. 1976) (holding professional status of defendants immaterial under *Goldfarb* since case involved alleged restraint and monopolization of a commercial aspect of the practice of medicine, "as distinguished from such other aspects as the professional qualifications of the practitioner"); *Feminist Women's Health Center v. Mohammed*, 586 F.2d 530, 546-47 (5th Cir. 1978) (holding *per se* analysis applicable to concerted activity of doctors, even in enforcing professional standards, where anticompetitive purpose was shown).

In this case, there is no question that "the challenged activity is by its nature and character, commercial." Indeed, the defendant foundations were founded to serve the purely commercial purpose of promoting the practice of medicine on a fee-for-service basis. Moreover, it is difficult to imagine conduct more commercial in nature that the price-fixing activities of these commercial trade associations. Considering the monopoly power of their membership and the anticompetitive impact of their conduct against the stan-

dard established by the Supreme Court for identifying unreasonably restrictive practices, it is clear that the challenged activity here falls within the category of *per se* violations. *See* Havighurst, *Professional Restraints, supra* at 377-378. Havighurst, *HMOs, supra* at 768; Kallstrom *Fee Schedules, supra* at 660, 692 n.197.

The commentators, including those cited by this Court, agree that horizontal price-fixing by professions is and should be subject to *per se* analysis. In its Memorandum and Order of June 5, 1979, at 9, this Court quoted from a student law review comment. Comment, *The Professions and Noncommercial Purposes: Applicability of Per Se Rules under the Sherman Act*, 11 U. Mich. J. of Law Reform 387 (1978) (hereinafter "Comment, *The Professions and Noncommercial Purposes.*" As the title of that comment indicates, its author was primarily concerned with the noncommercial aspects of professions, as described in the passage of the comment from which the Court quoted. He argues—as the prevailing case law holds—that the Rule of Reason should be applied to professional conduct which is (a) within the legitimate self-regulatory powers of the profession, (2) not primarily profit-oriented or commercial in purpose, and (3) undertaken in good faith. *Id.* at 399-400. But he also argues that conduct which does not meet those three requirements should *not* be excepted from *per se* treatment, particularly since *Goldfarb* and its progeny . . . indicate that some activities by professions, such as price-fixing, simply are devoid of any noncommercial purpose."

Id. at 399.[13] Thus, the Comment on which the Court relied actually concludes that "[p]*rice-fixing, . . . and other egregious activities should not escape per se condemnation* simply because they enjoy the respectability of having been mandated by the ethical rules of a given profession." *Id.* at 413 (emphasis added).

This conclusion accords with those of more mature commentators,[14] including Professor William Canby and Dean Ernest Gellhorn who, having studiously examined the application of the antitrust laws to physicians, conclude that "*price-fixing or equivalent conduct* (including fee advertising bans), allocation of clients, some forms of group boycotts and perhaps tying arrangements *will be subject to per se rules.*" Canby and Gellhorn, *Physician Advertising, supra* at 578. Indeed, Canby and Gellhorn predict that when a medical society's regulation of physician practices fits within one of those "egregious categories," it will not be necessary to show the actual competitive impact of the practice, "nor will an antitrust court hear, much less accept, organized medicine's justifications for the restraint." *Id.* Similary, Professor Clark Havighurst, a respected authority on the subject of the application of

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[13] See *id.* at n.36:

Indeed, there is nothing to indicate that the Supreme Court in *Goldfarb* was not applying a per se rule to the price-fixing arrangement in that case, and at least one federal court has so concluded. *See United States v. National Soc'y of Prof. Eng's*, 404 F. Supp. 457 (D.D.C. 1975), *aff'd*, 46 U.S.L.W. 4356 (1978). In oral argument before the Court in *Goldfarb*, Solicitor General Bork in fact pointed up the commercial-noncommercial dichotomy: "One searches in vain for any connection between professional ethics and price-fixing, and one searches in vain for the principle that price-fixing is ethical." 43 U.S.L.W. 3521, 3522 (1975).

[14] The second student note cited by this Court deals only with the self-regulation of professions and does not comment on the applicability or inapplicability of *per se* analysis to price-fixing by a professional group. Note, *Application of the Antitrust Laws to Anticompetitive Activities by Physicians*, 30 Rutgers L. Rev. 991 (1971).

the antitrust laws to the health care industry, persuasively argues that physicians' fee schedules, and particularly the fee schedules adopted by foundations for medical care, should be treated as *per se* unlawful. Havighurst, *HMO's and the Market for Health Service*, 35 J. Law and Comtemp. Prob. 716, 773 (1970). Accord, Kallstrom, *Fee Schedules, supra* at 680-84, 691-94.

Because the horizontal price-fixing challenged in this case is wholly commercial in nature and character, the *per se* rule is fully applicable here. Because this Court's ruling that an exemption from the *per se* rule exists in a case of horizontal price-fixing when "a profession is involved" is in conflict with the overwhelming weight of authority on this question, this motion for reconsideration should be granted.

V.

IF THIS COURT CONTINUES TO REFUSE TO APPLY THE *PER SE* RULE, THE DECISION SHOULD BE CERTIFIED FOR INTERLOCUTORY APPEAL UNDER 28 U.S.C. § 1292(b) BECAUSE THE DECISION IS A CONTROLLING QUESTION OF LAW AS TO WHICH THERE IS A SUBSTANTIAL GROUND FOR DIFFERNCE OF OPINION AND A DIRECT APPEAL WILL MATERIALLY ADVANCE THE ULTIMATE TERMINATION OF THE LITIGATION.

There can be little question that this Court's refusal to apply the *per se* rule to a horizontal price-fixing conspiracy presents a controlling question of law as to which there is a substantial ground for difference of opinion. In the unlikely event that this Court does not grant this motion for reconsideration or plaintiff's motion for summary judgment and permanent injuction, the certification of this case for interlocutory appeal would materially advance the ultimate termination of the litigation and preserve the resources of this Court and all of the parties by avoiding an unnecessary trial. *See, e.g., Reiter v. Sonotone Corp*, 47 U.S.L.W. 4672 (Sup. Ct., June 11, 1979); *In re Sugar Antitrust Litigation*,

588 F.2d 1270 (9th Cir. 1978); *Memorex Corp. v. International Business Machines Corp.*, 555 F.2d 1379 (9th Cir. 1977); *Little v. First California Co.*, 532 F.2d 1302 (9th Cir. 1976); *Duchess Music Corp. v. Stern*, 458 F.2d 1305 (9th Cir. 1972).

VI.

CONCLUSION

WHEREFORE, in the event that this Court does not grant plaintiff's concurrent motion for summary judgment and permanent injunction, Plaintiff the STATE OF ARIZONA respectfully prays that this Court enter its order:

1. Vacating the Memorandum and Order dated June 5, 1979, insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability, and

2. Granting plaintiff's motion for partial summary judgment on the issue of liability, or, alternatively,

3. Certifying that insofar as it denied plaintiff's motion for partial summary judgment on the issue of liability the Memorandum and Order dated June 5, 1979, involves a controlling question of law as to which there is a substantial ground for difference of opinion and that an immediate appeal from that portion of the order may materially advance the ultimate termination of the litigation.

DATED this 6th day of July, 1979.

(Signature omitted in printing.)

Verified JUL 13, 1979

(Caption omitted in printing.)

SUPPLEMENTAL RESPONSE OF THE STATE OF ARIZONA TO DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S FIRST SET OF INTERROGATORIES

Plaintiff STATE OF ARIZONA hereby supplements its Response to Interrogatories 3, 22-26, 29 and 32 of defendant Maricopa Foundation for Medical Care's First Set of Interrogatories, incorporating herein all objections set forth in plaintiff's initial response to those interrogatories and without in any way waiving or intending to waive but rather preserving and intending to preserve:

1. All questions as to the competency, relevancy, materiality, privilege and admissibility of these answers or the subject matter thereof, as evidence for any purpose, and all objections to the use of any of them for any purpose in any subsequent stage of this action or in any other proceeding,
2. The right to object on any ground at any time to demand for further response to these or any other interrogatories or other discovery procedures involving or relating to the subject matter of the interrogatories herein answered; and
3. The right at any time to revise, correct, add to or clarify any of the answers herein.

INTERROGATORY NO. 3(b)

With respect to paragraph 7, set forth by year the sums you pay . . . (b) "directly to doctors for services, goods and equipment."

SUPPLEMENTAL RESPONSE:

Without waiving or intending to waive any objection with respect thereto, the information sought may be derived or ascertained in part from the records of the Arizona Depart-

ment of Economic Security, the Arizona Department of Health Services, the Arizona State Hospital, and the Industrial Commission of Arizona produced by plaintiff for inspection and copying by defendants in response to defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, as well as the documents of certain other state agencies or programs which have previously been made available for inspection in response to that Request for Documents and Other Tangible Things.

INTERROGATORY NO. 22

Identify each (a) relative value schedule; (b) unit conversion factor; and (c) fee schedule established, maintained, revised or stabilized by you and with respect to each identify all documents, agreements, proposals, promises, forecasts, commitments, understandings, actions, representations and communications relating to it.

SUPPLEMENTAL RESPONSE:

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows:

Pursuant to Ariz. Rev. Stat. Ann. § 8-512, the Arizona Department of Economic Security has established and adopted a schedule setting out maximum allowable fees which the Department deems reasonable for services provided by the Department pursuant to that section. That fee schedule has been published as DES Rule R6-5-6001 and produced with related documents of the Department by plaintiff.

Pursuant to Ariz. Rev. Stat. Ann. § 23-908(B) the Industrial Commission of Arizona has adopted a schedule of fees for doctors' services to injured employees covered by the Workmen's Compensation Program of the State of Arizona. Copies of that fee schedule and documents relating to

it will be produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

With respect to the various other health programs administered by the Department of Economic Security, the Department of Health Services (including the Crippled Children's Hospital and the Arizona State Hospital) and the Department of Corrections, the information sought may be derived or ascertained from the records of those agencies produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Production and Tangible Things, and the additional documents which plaintiff has primarily made available for inspection by defendants.

INTERROGATORY NO. 23

Identify each office, agency, commission, department, division or other organizational entity of the State of Arizona which has participated at any time in any way in the preparation, establishment, maintenance, revision or stabilization of any (a) relative value schedule, (b) unit conversion factor or (c) fee schedule.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows:

The Department of Economic Security has established and adopted a schedule setting out maximum allowble fees which the Department deems reasonable for services provided by the Department pursuant to Ariz. Rev. Stat. Ann. § 8-512, as described in plaintiff's response to Interrogatory No. 22.

The Industrial Commission of Arizona has established and adopted a schedule of fees for doctors' services to injured employees covered under the Workmen's Compensation Program of the State of Arizona pursuant to Ariz. Rev. Stat. Ann. § 23-908(B).

In addition, other agencies, departments and programs of the State of Arizona may have used or referred to various relative value schedules, unit conversion factors or fee schedules in determining the amounts to be paid by the State of Arizona for doctors' services provided under various state programs. Information concerning the relative value schedules, unit conversion factors or fee schedules which might have been used or referred to by such state agencies, departments and programs may be ascertained or derived from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Production and Tangible Things, and the additional documents which plaintiff has previously made available for inspection and copying by defendants.

INTERROGATORY NO. 24

Identify each and every person within the definition of "State" who has participated at any time in the preparation, establishment, maintenance, revision or stabilization of any (a) relative value schedule; (b) unit conversion factor; or (c) fee schedule.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff responds as follows:

With respect to the schedule setting out maximum allowable fees which the Department of Economic Security deems reasonable for services provided by the Department

pursuant to Ariz. Rev. Stat. Ann. § 8-512, Ms. Alice McLain, Administrator of the Comprehensive Medical and Dental Program for Foster Children of the Arizona Department of Economic Security;

With respect to the fee schedule prepared and adopted by the Industrial Commission of Arizona for doctors' services to injured employees under the Workmen's Compensation Program of Arizona pursuant to Ariz. Rev. Stat. Ann. § 23-908(B), the members of the Industrial Commission of Arizona and the Executive Director and staff of the Industrial Commission of Arizona;

With respect to the other agencies, departments and programs of the State of Arizona which may have used or referred to any relative value schedule, unit conversion factor or fee schedule in determining the amounts to be paid by the State of Arizona for doctors' services provided under various State programs, the information sought may be ascertained or derived in part from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, and the additional documents which plaintiff has previously made available for inspection and copying by defendants.

INTERROGATORY NO. 25

Describe each relative value schedule, unit conversion factor and fee schedule used by the State of Arizona and with respect to each (a) identify who used it; (b) state the time period during which it was used; (c) state the manner in which it was used; and (d) state the purpose for which it was used.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows:

Plaintiff incorporates herein the information provided in plaintiff's answers to Interrogatories Nos. 22, 23, and 24 and further states that the information sought by Interrogatory No. 25 may be ascertained or derived in part from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, and from the additional documents which plaintiff has previously made available for copying and inspection by defendants.

INTERROGATORY NO. 26(a)

Set forth each and every method, procedure or process by which the State of Arizona purchases or otherwise obtains (a) health services . . . .

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers as follows with respect to doctors' services:

The State of Arizona Department of Economic Security purchases or otherwise obtains doctors' services provided under the Comprehensive Medical and Dental Program for Foster Children pursuant to Ariz. Rev. Ann. § 8-512.

The Industrial Commission of Arizona purchases or otherwise obtains doctors' services provided to injured employees under the Workmen's Compensation Program of the State of Arizona pursuant to Ariz. Rev. Stat. Ann. § 23-908.

The Arizona Department of Corrections purchases doctors' services on a contract basis, as reflected in the documents of that Department produced by plaintiff pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's Request for Documents and Tangible Things.

The Arizona Department of Health Services provides doctors' services at the Crippled Children's Hospital on the basis of contracts executed with individual doctors by that Department, as reflected in the documents which plaintiff will produce for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

The methods, procedures or processes by which certain other agencies, departments and programs of the State of Arizona purchase or otherwise obtain doctors' services may be derived or ascertained from the documents produced by plaintiff for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things, and the additional documents which plaintiff has previously made available for inspection by defendants.

INTERROGATORY NO. 29 (a)

Set forth each and every method, procedure or process by which the State of Arizona selects providers, suppliers and sellers of (a) health services . . . .

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers with respect to services, goods and products sold by doctors as follows:

The doctors who supply or sell services, goods and products provided by the State of Arizona through (a) the Comprehensive Medical and Dental Program for Foster Children administered by the Arizona Department of Economic Security, (b) the Workmen's Compensation Program administered by the Industrial Commission of Arizona, (c) the Sickle Cell Anemia Program administered by the Arizona Department of Health Services, (d) the Adult Cystic Fibrosis Program administered by the Arizona Department of Health Services, (e) the Indo-Chinese Refugee Medical

Assistance Program administered by the Arizona Department of Health Services, (f) the Day Care Program administered by the Arizona Department of Health Services, (g) the Veneral Disease Control Program administered by the Arizona Department of Health Services, (h) the Tuberculosis Control Program administered by the Arizona Department of Health Services, are selected by the individuals covered by those programs on an individual basis.

The doctors who supply or sell services, goods and products provided by the State of Arizona at the Crippled Children's Hospital are selected in accordance with the By-Laws of that Hospital, which will be produced by plaintiff for inspection and copying by defendant pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

The doctors who supply or sell services, goods and products provided by the State of Arizona Department of Corrections are selected on a contract basis as reflected by the documents produced by plaintiff with plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Things.

The methods, procedures or processes by which the State of Arizona selects the doctors who supply or sell services or goods and products provided by the State of Arizona through various programs administered by the Department of Economic Security and the Department of Health Services can be derived or ascertained from the documents which plaintiff will produce for inspection and copying by defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Objects.

INTERROGATORY NO. 32

Identify each and every person who provides, supplies or sells (a) health services . . . to the State of Arizona.

RESPONSE

Without waiving or intending to waive any objection with respect thereto, plaintiff answers with respect to the services, goods and products sold by doctors to the State of Arizona that the identity of the doctors who supply or sell such services may be derived or ascertained in part from the documents which plaintiff has produced and will produce for inspection and copying by the defendants pursuant to plaintiff's Supplemental Response to Defendant Maricopa Foundation for Medical Care's First Request for Documents and Tangible Objects, and the additional documents which plaintiff has previously made available for inspection and copying by defendant Maricopa Foundation.

(Signature and notary clause omitted in printing.)

Filed - JUL 18, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

MEMORANDUM AND ORDER

Defendants Maricopa Foundation for Medical Care and Pima Foundation for Medical Care have moved to vacate the order of the Court dated April 30, 1979, which continued until further order the temporary restraining order contained in Paragraph 6 of the order dated November 2, 1978. The defendats have established irreparable injury to themselves by substantiating without dispute through affidavits that participating physicians have threatened to withdraw from the defendant foundations. The plaintiff, on the other hand, has failed to show injury to itself and those it represents that cannot be compensated by money damages or that could be avoided if the motion to vacate the temporary restraining order were denied. The plaintiff has also not demonstrated that the injury to it in granting the motion exceeds that incurred by defendants in denying the motion. The plaintiff, moreover, has not shown that it is likely to succeed on the merits based on the Rule-of-Reason approach adopted here, which requires relatively complex factual inquiries. Thus, whether treated as a motion to va-

cate the temporary restraining order, or, because of the lapse of time and the preparation of the parties, as an application for a preliminary injunction, the defendants are entitled to relief. Therefore,

IT IS ORDERED:

The defendants' motion to vacate the April 30, 1979, temporary restraining order is granted.

DATED July 17, 1979.

/s/
United States District Judge

Filed - JUL 19, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

NOTICE OF APPEAL

NOTICE IS HEREBY GIVEN that the STATE OF ARIZONA, plaintiff above named, hereby appeals to the United States Court of Appeals for the Ninth Circuit from the order granting defendants' motion to vacate the April 30, 1979 temporary restraining order which was entered in this action on July 17, 1979.

DATED: July 19, 1979

(Signature omitted in printing)

Filed - JUL 23, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S RESPONSE TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND PERMANENT INJUNCTION

Preliminary Statement

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits this memorandum in opposition to plaintiff's motion for summary judgment and permanent injunction.

By its Memorandum and Order dated June 5, 1979 at 12, the Court held that "there is insufficient evidence as to the *purpose* and *effect* of [defendants'] allegedly unlawful practices and the *power* of the defendants" upon which to base a motion for summary judgment in plaintiff's favor under the Rule of Reason. (emphasis added) The Court therefore denied plaintiff's Motion for Partial Summary Judgment on the Issue of Liability "with leave to file a similar motion based on *additional evidence* if appropriate." (emphasis added) *Id.* at 13.

Plaintiff's present motion for summary judgment is inappropriate, since (1) it relies on virtually no evidence that was not before the Court at the time it considered plain-

tiff's motion for partial summary judgment* and (2) it appears to be an attempt to obtain a final determination before Maricopa Foundation obtains the discovery to which it is entitled. Because plaintiff's present motion disregards the Court's instructions in its Memorandum and Order dated June 5, 1979 and is patently without merit, (as more fully set forth below), Maricopa Foundation respectfully prays that the Court deny the motion and award Maricopa Foundation its reasonable attorneys' fees incurred in responding to yet another of plaintiff's unnecessary and premature motions.

Argument

A. PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT SHOULD BE DENIED BECAUSE THOSE "FACTS" UPON WHICH PLAINTIFF RELIES EITHER LACK EVIDENTIARY SUPPORT OR ARE CONTROVERTED BY MARICOPA FOUNDATION.

Under the Rule of Reason, the Supreme Court has long held that "[t]he true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Board of Trade of Chicago v. United States*, 246 U.S. 231, 38 S.Ct. 242, 244 (1918). *Accord National Soc'y of Professional Engr's v. United States*, 98 S.Ct. 1355, 1364-65 (1978). In order to determine

*The only additional "evidence" upon which plaintiff relies is the affidavit of Alice McClain attesting that appended competitive bids with respect to providing administrative services for the Comprehensive Medical and Dental Program for Foster Children of the State of Arizona are records maintained in the normal course of business. Significantly, those bids (one of which is that of Maricopa Foundation) fall within Maricopa Foundation's discovery request. Rather than producing them in the course of discovery as promised during the Local Rule 42A Conference held June 21, 1979, plaintiff appended the responsive documents as exhibits to its motion for summary judgment. It was not until a full week later that these responsive documents were produced to Maricopa Foundation, *subject to plaintiff's continuing objection that they were irrelevant.*

whether an activity promotes or suppresses competition the Court must examine a number of discrete factual questions. In *Board of Trade of Chicago v. United States*, 246 U.S. 231, 38 S.Ct. 242 (1918), the Court held that the district court had erred in excluding evidence with respect to the history and purpose of the defendant's "call rule" (whereby exchange members were prohibited from purchasing or offering to purchase grain "to arrive" after close of bidding at a price other than the closing bid) and stated:

> "[T]he court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts."

38 S.Ct. at 244.

Consistent with *Chicago Board of Trade* this Court, by its June 5, 1979 Memorandum and Order, directed that similar evidence be adduced by the parties by which to determine whether the challenged activities of Maricopa Foundation violate the federal and state antitrust laws. Rather than complying with the Court's directive, plaintiff has submitted a motion for summary judgment based upon purportedly undisputed "facts" drawn from the same record that was before the Court when it denied plaintiff's earlier motion for summary judgment. Moreover, as Appendix A hereto reflects, "facts" asserted by plaintiff pertaining to material areas of inquiry required under a Rule of Reason analysis are virtually unsupported by the record and constitute nothing more than plaintiff's conclusory allegations. Plaintiff's interposing of a motion for summary judgment at this juncture, therefore, can only be viewed as an attempt to preclude Maricopa Foundation

from obtaining relevant discovery.*

Maricopa Foundation controverts plaintiff's purported factual assertions and will demonstrate at trial that its comprehensive medical insurance program provides a competitive alternative to third party payors (and through them to the public) that directly promotes rather than suppresses competition. Contrary to plaintiff's bald assertions, third party payors are free to underwrite or refuse to underwrite a Maricopa Foundation plan. Maricopa Foundation simply offers its program as one of many alternatives that a third party payor may choose to underwrite. [Affidavit of Anthony D. Mitten, dated November 17, 1978 appended to Maricopa Foundation's Motion to Dismiss the Compaint "Mitten Aff.", para.2] In many instances, a Maricopa Foundation plan is offered by employers to their employees as an alternative that they may accept or reject in favor of another plan of insurance. Illustrative is the City of Phoenix which offers its employees their choice of the Maricopa Foundation plan, the Arizona Health Plan and the Arizona Blue Cross Health Maintenance Organization.

In addition, member physicians are free to participate simultaneously in insurance programs other than that of Maricopa Foundation and to provide services to patients directly or through third party payors or any other basis that the physicians and the persons to whom they are providing services choose. [Mitten Aff. para. 4] In any event, participation in Maricopa Foundation does not affect the billings of member physicians to their patients. [*Id.*, para. 3] If Maricopa Foundation is eliminated as a competitor to

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*Immediately upon receiving this Court's Memorandum and Order dated June 5, 1979, Maricopa Foundation requested plaintiff both by telephone and by letter to commence fulfilling its discovery obligations to Maricopa Foundation. It was not until July 13, 1979 (one week after plaintiff filed its present motion for summary judgment) that plaintiff responded to Maricopa Foundation's interrogatories and document demands. Those responses were not only incomplete, but were replete with objections as to the relevancy of the discovery sought by Maricopa Foundation.

closed panel health maintenance organizations and other prepaid insurance programs, those remaining competitors may have less of an incentive to provide low cost, yet comprehensive medical care to consumers. The competitive impact of Maricopa Foundation insurance programs is indisputably a material factual issue that is yet to be determined.

Whether there are less restrictive means by which Maricopa Foundation may obtain its twin objectives of promoting fee-for-service medical care while providing the most comprehensive medical insurance at a competitive cost* is also a factual question which is at issue and must be determined. The Court should not accept plaintiff's unsupported conclusion that less retrictive alternatives exist. Plaintiff's very assertion of its contention compels the conclusion that the industry in which Maricopa Foundation competes must be examined in order to determine whether a less restrictive alternative in fact exists by which Maricopa Foundaiton can achieve its purposes. That determination, in turn, requires presentment of evidence pertaining to the impact of Maricopa Foundation's practices. Plaintiff's purported reliance upon pricing data, although actual price information is notably absent from plaintiff's papers, further buttresses the conclusion that competent evidence of impact is required under a Rule of Reason analysis.

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*Plaintiff asserts that Maricopa Foundation's purpose of "promot[ing] the interests of fee for service medicine . . ." [Plaintiff's Motion for Summary Judgment and Permanent Injunction "Plaintiff's Motion" at 5], demonstrates anticompetitive purpose. On its face, the preservation of competitive alternatives in an industry should be deemed to be consistent with the objectives of the antitrust laws. Indeed, the uncontroverted affidavit of Anthony D. Mitten establishes that "Maricopa Foundation was established to provide residents of Maricopa County with a competitive alternative to utilization of closed panel prepaid health insurance plans." [Mitten Aff. para. 2]

Because material issues of fact are yet to be determined, plaintiff's motion for summary judgment should be denied.

B. THE RULE OF REASON PRECLUDES THE GRANTING OF SUMMARY JUDGMENT SINCE MATERIAL FACTS WITH RESPECT TO MARICOPA FOUNDATION'S PURPOSE, ITS POWER AND THE EFFECT OF ITS CHALLENGED ACTIVITIES ARE IN DISPUTE.

Summary judgment is particularly inappropriate here because complex, disputed facts must be evaluated by the Court under a Rule of Reason analysis. Indeed, by its Memorandum and Order filed July 18, 1979 at 2, the Court held, on a record virtually identical to that presently before it, that "plaintiff . . . has not shown that it is likely to succeed on the merits based on the Rule of Reason approach adopted here, which requires relatively complex factual inquiries." Moreover, the very cases which plaintiff claims entitle it to summary judgment under the Rule of Reason amply demonstrate that that standard mandates detailed factual determinations by a trier of fact with respect to the purpose and impact of the alleged restraint and the power of the defendant imposing it. Illustrative are *Mackey v. National Football League*, 543 F.2d 606, 609 (9th Cir. 1976) (injunction issued only after 55 days of trial that produced a transcript in excess of 11,000 pages); *Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1183 n.46 (D.C. Cir. 1978) (2,000 page record of detailed facts consisting, *inter alia*, of the history of the professional football industry); *Northern California Pharmaceutical Ass'n v. United States*, 306 F.2d 379, 391 (9th Cir. 1962) (over 1,000 pages of trial transcript in criminal proceeding for violation of Section 1 of the Sherman Act); *Plymouth Dealers' Ass'n v. United States*, 279 F.2d 128, 129 (9th Cir. 1960) (trial to jury under *per se* standard); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29, 30 (D. Utah 1962) (judgment against defendant, under *per se* standard, only after trial to the court

even though most of the facts had been stipulated by the parties).*

The only case cited by plaintiff in which summary judgment was entered under the Rule of Reason involved a discretionary restraint on employment that was neither limited as to time or extent.** *Kapp v. National Football League*, 390 F. Supp. 73, 82 (N.D. Cal. 1974), *aff'd*, 586 F.2d 644 (9th Cir. 1978). In granting summary judgment with respect to certain restrictive rules, the district court stated:

> "In applying the reasonableness test we have in mind that the issue of reasonableness is *ordinarily* in such genuine dispute that a case cannot be resolved on a motion for summary judgment." (emphasis added)

390 F. Supp. at 82. While some of the restrictive rules were "patently unreasonable" because they would "*perpetually* restrain a player from pursuing his occupation among the clubs of a league that holds a virtual monopoly of profes-

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*The case upon which plaintiff places primary reliance to its entitlement to summary judgment, *United States v. Southern Motor Carriers Rate Conference, Inc.*, 467 F. Supp. 471 (N.D. Ga. 1979), did not, as plaintiff represents, grant summary judgment under the Rule of Reason. In fact, after granting summary judgment under the *per se* rule, the court merely intimated, "[n] or would we *necessarily* reach a different result under rule of reason analysis. . . . The focus would continue to be on the *effect* of collective rate-making on price competition among intrastate carriers." *Id.* at 486-87 n.11 (emphasis added).

**Plaintiff additionally cites *Associated Press v. United States*, 326 U.S. 1 (1945) and *Silver v. New York Stock Exch.*, 373 U.S. 341 (1963) in which summary judgments were granted. Both cases, however, involved concerted refusals to deal in which the underlying facts were undisputed. Moreover, notwithstanding plaintiff's mercurial shift from its characterization of third party payors as co-conspirators [Complaint, para. 9] to victims of the defendants' newly-alleged concerted refusals to deal, there is no factual support whatsoever for plaintiff's most recent theory. *See* Appendix A attached hereto. *Silver* is further inapposite because the Court analyzed the facts under a *per se* standard, rejecting any defense of reasonableness derived from compliance with SEC rules because the challenged practice on its face clearly exceeded the purposes of the Securities Exchange Act. 373 U.S. at 365.

sional football employment in the United States" and because they "permit[] virtually *perpetual* boycott . . ." the court refused to grant summary judgment with respect to the reasonableness of the "option rule" that left the matters of duration of contracts and salary to free negotiation between players and clubs. *Id.* at 82-83 (emphasis in original).

Similarly, summary judgment is inappropriate here because physicians specifically agree that "participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient."* Member physicians clearly are free, unlike National Football League players, to negotiate either with third party payors or with non-Maricopa Foundation insured patients as to the compensation that they will receive from them for services rendered. Third party payors are similarly free to underwrite or refuse to underwrite Maricopa Foundation plans. Patients, too, (including those insured under Maricopa Foundation-endorsed insurance plans) may seek either the services of member of non-member physicians. In either case, the third party payor will pay to the provider up to Maricopa Foundation's maximum level of reimbursement.** [Mitten Aff. para. 4] In the case of a Maricopa Foundation member, however, since he has agreed in advance to accept the Maricopa Foundation level of reimbursement as full compensation, he is precluded from billing the patient for the balance of his normal charge. A non-member, of course, may bill the patient to the extent that the Maricopa Foundation maximum level does not fully reimburse him. On their face, Maricopa Foundation's activities do not in any sense impede free negotiation in the market. At a minimum, the impact of the practices is in clear dispute.

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*Mitten Aff. para. 3 and Exhibit A thereto.

**Those physicians who charge less than Maricopa Foundation's maximum level of reimbursement receive payment only to the extent of their actual charges. [Mitten Aff. para. 4]

Plaintiff's reliance upon the mere circulation of relative value guides and conversion factors to support its entitlement to summary judgment is similarly insufficient. The State itself engages in the same activities through the Department of Economic Security and the Industrial Commission of Arizona.* While the Supreme Court in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) held that a mandatory minimum fee schedule with respect to the prices to be charged for legal services violated Section 1 of the Sherman Act, there is no proof of uniform pricing here.** The Supreme Court said:

> "A purely advisory fee schedule issued to provide guidelines, or an exchange of price information without a showing of an actual restraint or trade, would present us with a different question . . .
>
> * * * *
>
> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act."

421 U.S. at 781, 788 n.17.

Plaintiff has presented no factual support for its claim that Maricopa Foundation's maximum level of reimbursement either is intended to be an advisory fee schedule or has operated as such. There is no evidence of any coercion to force adherence in billing to Maricopa Foundation's maximum reimbursement levels. Indeed, there is no evidence of any

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*Supplemental Responses 22 through 25 of the State of Arizona to Defendant Maricopa Foundation for Medical Care's First Set of Interrogatories.

**See illustratively exhibits 1 through 4 attached to Appendix A hereto which clearly reflect the disparity in prices charged by Maricopa Foundation members for services rendered in connection with four common surgical procedures.

effort to encourage any doctors to change any price for a medical service. Instead, plaintiff relies entirely on theoretical hypotheses from law review articles unsupported by any facts.

Plaintiff's further argument with respect to the anticompetitive nature of relative value guides is totally misplaced. To support its contention that relative value guides in and of themselves are anticompetitive, plaintiff relies upon irrelevant and immaterial consent decrees, none of which adjudicated the legality of the relative value guides. Illustrative is the Settlement Agreement entered in connection with *Ohio v. Ohio Medical Indemnity, Inc.*, CIV No. C-2-75-473 (S.D. Ohio), a copy of which is appended to plaintiff's motion:

> "Nothing herein shall constitute an adjudication, determination or finding of fact or law relative to any issue raised in this cause nor shall this Dismissal Order constitute evidence against, or an admission by, any party . . ."

[Dismissal Order appended as Appendix C to Settlement Agreement, para. 5] Moreover, in the only decision to date pertaining to the dissemination and use of relative value guides, *United States v. American Soc'y of Anesthesiologists, Inc.*, No. CIV 4640 (KTD) (S.D.N.Y., filed June 21, 1979), the Court denied plaintiff the relief it sought holding that:

> "[T]he guides facilitated the interchange between insurance carriers and physicians . . .
>
> * * * *
>
> When viewed in the context of this unusual market, it would seem that *defendant's activities tended to promote the interplay of such competitive forces as existed in the area* . . ." (emphasis added)

[Slip. Op. at 37-38]

In view of the Supreme Court's intimation in *Goldfarb v. Virginia State Bar* and the holding in *United States v. American Soc'y of Anesthesiologists, Inc.* that dissemination and use of the Anesthesiology Relative Value Guide (which Maricopa Foundation uses in part)*[1] does not violate the antitrust laws and is in fact, procompetitive, Maricopa Foundation rather than plaintiff is more properly entitled to summary judgment, if any such judgment could be granted. In any event there is insufficient evidence upon which to base a Rule of Reason determination in plaintiff's favor and many of the supposed facts upon which plaintiff relies are controverted by Maricopa Foundation. Not only has plaintiff not shown entitlement to summary judgment, but for all the reasons set forth in the Memorandum in Support of Defendant Maricopa Foundation for Medical Care's Motion to Vacate Temporary Restraining Order of April 30, 1979, which is incorporated herein by reference, plaintiff has failed to show any entitlement to injunctive relief.*[2] Therefore, Maricopa Foundation respectfully submits that plaintiff's motion for summary judgment and permanent injunction be denied in its entirety.

July 23, 1979

(Signatures omitted in printing.)

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*[1] As does the State of Arizona itself through its Industrial Commission. *See* "Medical Fee Schedule" adopted by The Industrial Commission of Arizona, December 1, 1970, Appendix I.

*[2] Plaintiff's request for "an order specifying the issues of law . . . which remain to be tried . . ." [Plaintiff's Motion at 41] reflects its habitual overreaching. Rule 56(d) provides only that a court "shall, if practicable ascertain what material facts exist without substantial controversy and what material facts are actually in good faith controverted. It shall thereupon make an order specifying the facts that appear without substantial controversy . . ."

APPENDIX A

Illustrative Conclusory Statements Asserted by Plaintiff as "Facts" that Are Unsupported by the Record

PLAINTIFF'S ALLEGATION	PLAINTIFF'S SUBSTANTIATION
A. Power.	
"[E]ach fee-for-service physician possesses a significant degree of natural monopoly power . . ." [Plaintiff's Motion at 19, 20]	No factual support, relies upon Havighurst, "Health Maintenance Organizations and the Market for Health Services," 35 *Law and Contemp. Prob.* 716, 768 (1970)
"It is therefore, no exaggeration to state that defendant trade associations [the Foundations] . . . are in effect combinations of monopolists with unique power as sellers in the marketplace."	No factual support.
B. Effect.	
"[T]he Court is presented with an agreement among competitors not to discuss prices at all with third part payors . . ." [Plaintiff's Motion at 20]	No factual support.
"[T]hird parties that underwrite foundation-approved plans have had no vote whatsoever on the professional fees they must pay under those plans." [Plaintiff's Motion at 24]	No factual support.

"By setting a cartel price for the services they provide to insured persons, the foundations' member doctors have directly restricted independent pricing of doctors' services and have curtailed the bargaining power which third party payors might have exercised in the absence of a doctors' cartel. "[Plaintiff's Motion at 22]	No factual support; relies only upon Havighurst, *supra*.
"[The defendants' purported horizontal price fixing] is a direct and severe restraint on the bargaining power of the insurer in negotiating reimbursement schedules with fee-for-service physicians." [Plaintiff's Motion at 26]	No factual support.
"The procedures by which the defendants have maintained and revised those fee schedules through widespread price surveys and price agreements ... have clearly been intended to result in agreed-upon price levels for doctors." [Plaintiff's Motion at 27]	No factual support.
"Defendants have made it clear that the fee schedules they have proposed to their members for adoption represented a consensus on the prices which doctors in the community *would* be charging in the period after the fee	No factual support.

schedules were adopted . . ." (emphasis added) [Plaintiff's Motion at 28]	
"[Defendants'] uniform fee schedules and fee increases . . . have suppressed the individual pricing of medical services by fee-for-service doctors and third payors." [Plaintiff's Motion at 19]	No factual support, stating instead that "No elaborate analysis is needed to discern the anticompetitive impact of such conduct."
"[T]he foundations' uniform fee schedules have led to uniform pricing . . ." [Plaintiff's Motion at 16]	No factual support, stating, without citation to the record, that "85 to 95 percent of foundation members bill at or above the rates set in the foundation fee schedules." [Plaintiff's Motion at 16] Significantly, charts to which plaintiff may be referring [attached hereto as Exhibits 1-4] reflect a great disparity in the prices charged by physicians for professional services with respect to four typical surgical procedures.
"[A]fter an increase in the level of fees set in the foundation fee schedule has been adopted by the foundation members, overall doctors' fees have risen to that level." [Plaintiff's Motion at 16]	Maricopa Foundation RFA's 228-35 relied upon by plaintiff, do not support plaintiff's allegation; moreover the AMA and HIAA data cited has not been determined to be either statistically competent or admissible.
"[T]he agreed upon increases in defendants' fee schedules	The record cited [Maricopa Foundation's Responses to

have resulted in increases in the premiums charged on those plans." [Plaintiff's Motion at 14]

plaintiff's First Request for Admissions "RFA" and Interrogatories 143 & 224] reflect only that Maricopa Foundation sought actuarial advice. Moreover, the deposition transcript relied uon by plaintiff provides as follows: "In this case, [an insurance premium rate adjustment] evidently [followed an increase in Maricopa Foundation's Minimum Standards] . . . for this particular insurer for the Scottsdale School's Program, *but not for every program and every insured.*" (emphasis added) [Mitten Depo., Vol. 1 at 64]

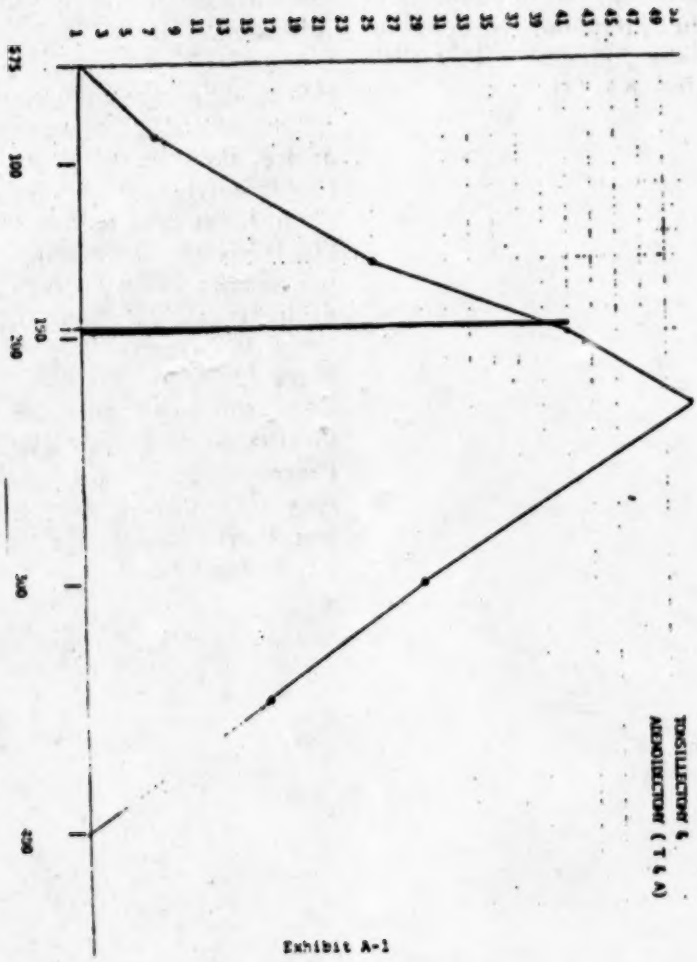

Exhibit A-1

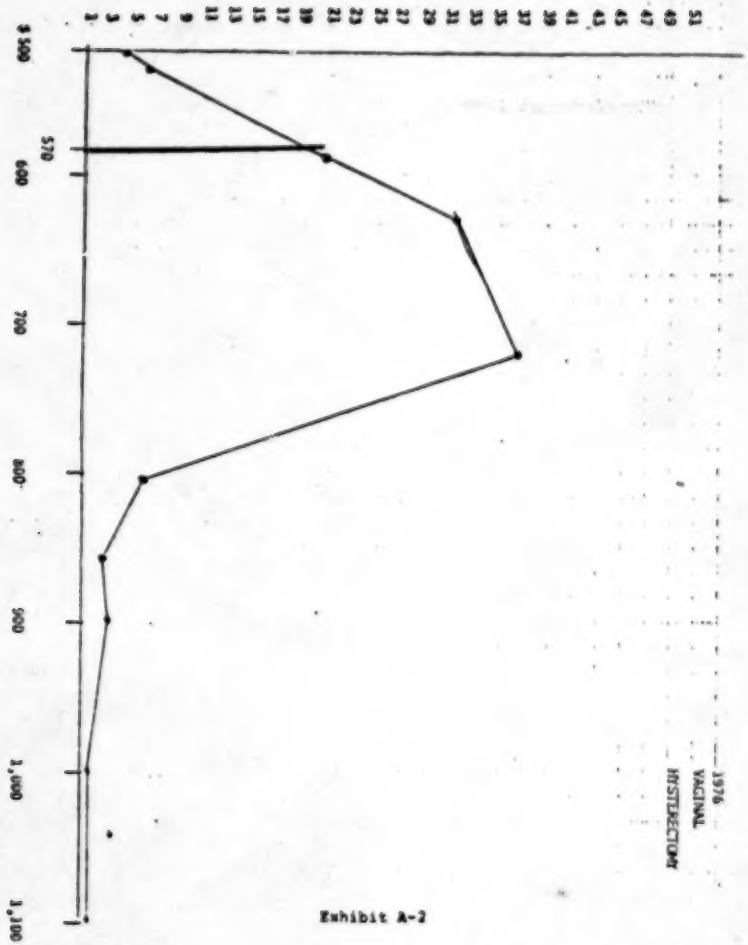

Exhibit A-2

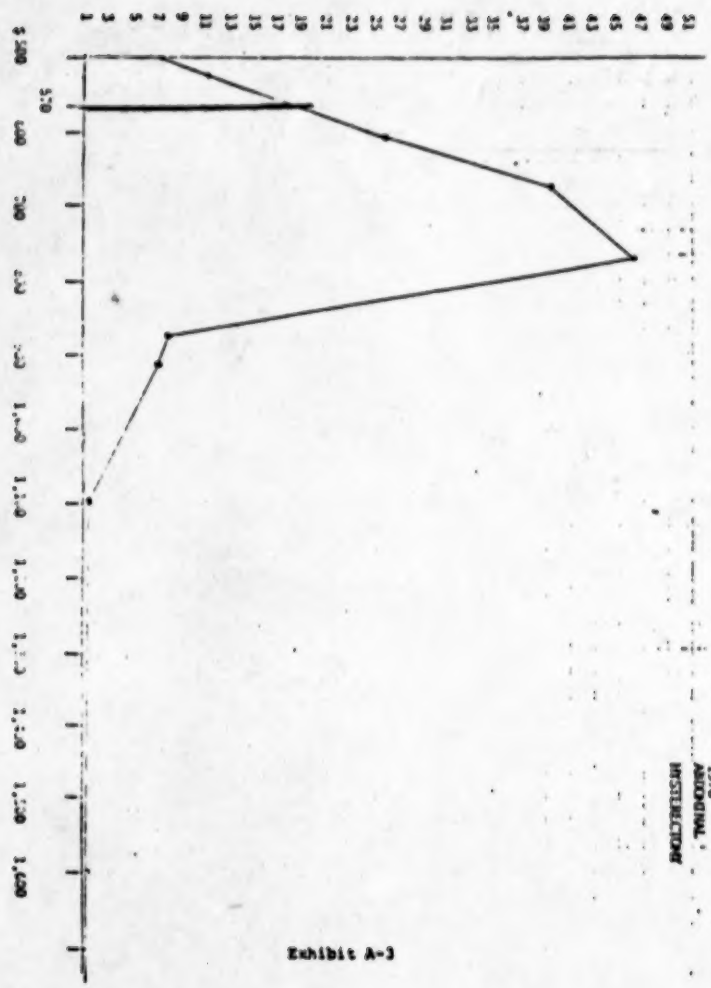

Exhibit A-3

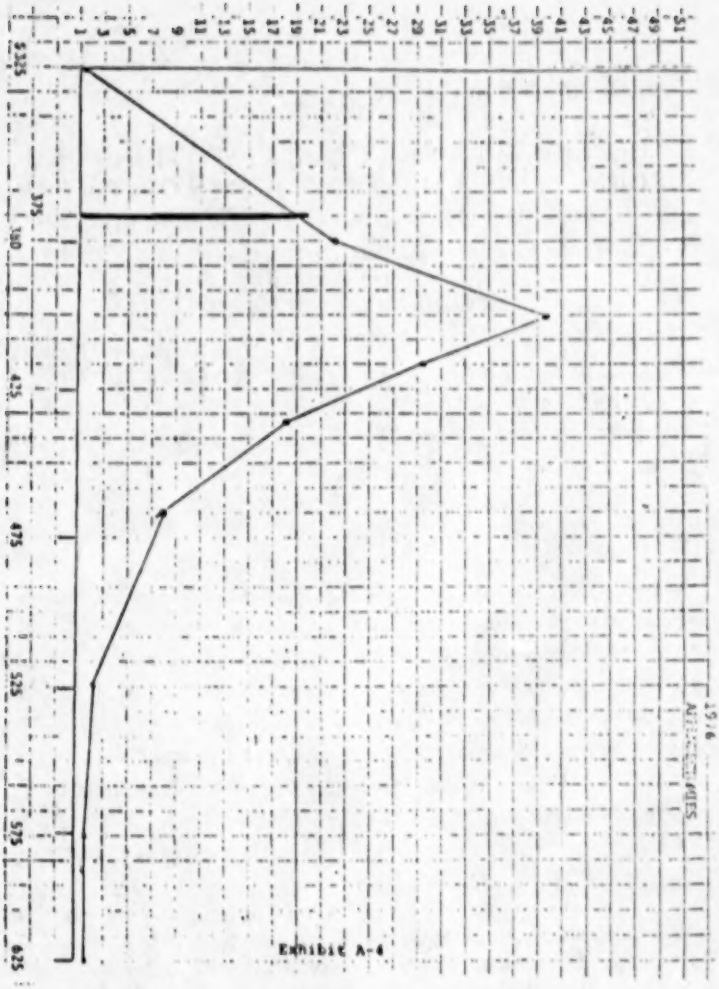
325
375
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Exhibit A-4

Filed - JUL 23, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR RECONSIDERATION OF MEMORANDUM AND ORDER OF JUNE 5, 1979

Preliminary Statement

This memorandum is submitted by defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") in opposition to plaintiff's Motion for Reconsideration of Memorandum and Order of June 5, 1979, or, Alternatively, Motion for Certification for Interlocutory Appeal Pursuant to 28 U.S.C. § 1292(b) of Memorandum and Order of June 5, 1979.*[1]

In support of its motions, plaintiff has provided the Court with a lengthy—albeit inaccurate—review of antitrust law and a totally misleading characterization of what plaintiff contends are uncontroverted facts;*[2] plaintiff has not, however, provided the Court with any new arguments or intervening developments that might properly form the basis of a motion for reconsideration. Instead, plaintiff simply rehashes arguments already advanced and rejected by the Court in determining that the Rule of Reason standard

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*[1] Because plaintiff's motion for reconsideration seeks to renew its motion for partial summary judgment on the issue of liability, Maricopa Foundation incorporates herein its previously filed Statement of Material Facts as to Which There Is a Genuine Issue Precluding Summary Judgment in Favor of the Plaintiff on the Issue of Liability (December 11, 1978).

*[2] Those "facts" are dealt with in Maricopa Foundation's Response to Plaintiff's Motion for Summary Judgment and Permanent Injunction (July 23, 1979).

should govern the resolution of this case.** The burden on Maricopa Foundation in being forced to respond to these meritless motions is unjustifiable; it constitutes harrassment of Maricopa Foundation, and an unwarranted imposition on the resources of the Court.*** Therefore, Maricopa Foundation submits that the motions should be denied, that Maricopa Foundation should be awarded its reasonable attorneys' fees and that the Court should impose such further sanctions as it may deem appropriate.

Plaintiff's motion for reconsideration rests upon a fundamental misapprehension as to applicable law and a sweeping disregard of the facts in this case. In its Memorandum and Order of June 5, 1979, the Court noted the undisputed fact that the doctors who agree to participate in the Foundation-approved plans are free to set the prices they charge their patients. (Memorandum and Order at 2.) The only thing to which any physician has agreed is that he or she will accept the maximum level of reimbursement applicable to Foundation-endorsed health insurance plans as payment in full for services provided to patients insured under such plans. *Id.*

Nevertheless, plaintiff again contends in its motion that it has established by uncontroverted evidence existence of a naked horizontal price-fixing conspiracy among competitors that should be declared *per se* illegal. (See, *e.g.*, Plaintiff's Motion for Reconsideration at 48.) In its Memorandum and Order of June 5, 1979, the Court properly declined plaintiff's invitation to place an improper, conclusory label on

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**The proper standard to be applied was an issue thoroughly briefed by the parties. See Maricopa Foundation for Medical Care's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability (December 11, 1978); Reply Memorandum in Support of Plaintiff's Motion for Partial Summary Judgment on the Issue of Liability (December 21, 1978).

***Plaintiff continues its efforts to have the same questions decided over and over again. On July 19, 1979, plaintiff noticed an appeal from this Court's Order of July 17, 1979 granting Maricopa Foundation's Motion to Vacate Temporary Restraining Order of April 30, 1979.

Maricopa Foundation's conduct and then mechanically apply *per se* rules developed in other contexts to the acts of Maricopa Foundation. Plaintiff's present attack on the Court's decision cannot alter the appropriateness of the approach taken and the propriety of the conclusions reached therein.

Argument

A. THE COURT'S MEMORANDUM AND ORDER OF JUNE 5, 1979 CORRECTLY RECOGNIZED THAT THE FORMALISTIC APPROACH ARGUED FOR BY PLAINTIFF SHOULD BE REJECTED IN FAVOR OF A REASONED ANALYSIS OF THE CHALLENGED PRACTICES.

Concluding that the Rule of Reason was the proper analytical framework in which to examine Maricopa Foundation's conduct, this Court stated: "Although the per se approach avoids inquiry into difficcult economic issues, a recent antitrust trend appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust laws." *Id.* at 7. This conclusion is in harmony with recent pronouncements of the Supreme Court that have eschewed antitrust analysis artifically divorced from the economic realities of the particular case.

In *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 97 S. Ct. 2549 (1977), the Supreme Court, overruling its earlier decision in *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365, 87 S. Ct. 1856 (1967), condemned the precipitous application of *per se* rules in antitrust cases. The Court noted that the *Schwinn* case itself "was an abrupt and largely unexplained departure from *White Motor Co. v. United States*, 372 U.S. 253, 83 S. Ct. 696, 9 L. Ed. 2d 738 (1963), where only four years earlier the Court had refused to endorse a *per se* rule for vertical restrictions." *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 97 S. Ct. at 2556. In rejecting the truncated *per se* analysis employed in *Schwinn*, the Court plainly insisted that courts focus on the

substantive orientation of the antitrust laws in analyzing particular cases, declaring: "Realities must dominate judgment.... The Anti-Trust Act aims at substance." *Id.*, *quoting Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 360 (1933). The Court emphasized that "[p]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anti-competitive," 97 S. Ct. at 2558, and warned: "[W]e ... make clear that departure from the rule of reason standard must be based upon demonstrable economic effect rather than—as in *Schwinn*—upon formalistic line drawing." *Id.* at 2562. By applying conclusory labels to the practices here and arguing for a blind application of the *per se* rule with no showing of "demonstrable economic effect," plaintiff asks the Court to disregard this admonition.

More recently, in *Broadcast Music, Inc. v. Columbia Broadcasting*, 99 S. Ct. 1551 (1979), the Court again rejected the simplistic *per se* approach to antitrust analysis favored by plaintiff. Holding that the Rule of Reason should govern the determination of the legality of the blanket licensing practice at issue, (which had been held to be *per se* illegal price-fixing by the Court of Appeals), the Supreme Court observed that while the *per se* rule "is a valid and useful tool of antitrust policy and enforcement," courts must not be too quick to seize upon it as a replacement for reasoned analysis of challenged practices: "[E]asy labels do not always supply ready answers." *Id.* at 1556.

Plaintiff's rush to affix the label of horizontal price-fixing to Maricopa Foundation's practices stands at odds with the searching analysis mandated by *Broadcast Music:*

> To the Court of Appeals and CBS, the blanket license involves 'price fixing' in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license it sells. But this is not a question simply of determining whether two or more potential competitors have literally 'fixed' a 'price'. As generally used in the antitrust field, 'price fixing' is a shorthand way of de-

> scribing certain categories of business behavior to which the *per se* rule had been held applicable. The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is 'plainly anticompetitive' and very likely without 'redeeming virtue.' Literalness is overly simplistic and often overbroad. . . .
>
> Consequently, '[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations. . . .' [Citation omitted.]

Id. at 1557. The Supreme Court concluded that ["n]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints." *Id.* at 1564. The Foundation-endorsed insurance plans are, it is respectfully submitted, subject to the same analysis as "separate products" as the blanket licenses in the *BMI* case. As in *BMI*, plaintiff has failed to establish any agreement by competitors as to prices they will sell at on an individual basis.*

As this Court recognized in its Memorandum and Order of June 5, 1979, the Supreme Court has underscored the lack of utility from both a social and economic perspective of mechanical resort to the *per se* rule. This Court correctly stated that "[a]nother consideration in determining whether to apply the Rule of Reason approach is that a profession is involved here." (Memorandum and Order at 8-9.) The antitrust laws were not intended to straight-jacket imaginative experimentation in fields, such as the profes-

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*The Court noted that blanket licensing had produced "substantial lowering of costs, which is of course potentially beneficial to both sellers and buyers," *id.* at 1563, and that "[t]he individual composers and authors have neither agreed to not to sell individually in any other market nor use the blanket license to mask price fixing in such other markets." *Id.* at 1564. These very same factors are present here. Maricopa Foundation has maintained throughout these proceedings, and the record bears it out, that participating physicians have not agreed upon the fees to be charged patients and that Foundation-endorsed health insurance plans offer a lower cost alternative to other health insurance plans.

sions, not traditionally subject to antitrust scrutiny. Therefore, as this Court further noted, it is inappropraite to make a wholesale transfer of rules fashioned in a purely commercial context to activities involving professionals. (See *id.* at 8-12.)

In *National Soc'y of Professional Eng'rs v. United States*, 425 U.S. 679, 98 S. Ct. 1355 (1978), the Supreme Court cautioned that "certain practices by members of a learned profession might survive scrutiny under the Rule of Reason even though they would be viewed as a violation of the Sherman Act in another context." 98 S. Ct. at 1362.* *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975) ("It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas"); *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626, 632 (9th Cir.), *cert. denied*, 434 U.S. 825 (1977) ("[T]he Supreme Court does not require that the practices challenged here be treated the same as would be proper if dentistry were merely a commercial enterprise"). This recognition of the professions as unsuited to the application of the same rules as commercial enterprises—together with the Supreme Court's expressed disfavor of unthinking *per se* analysis even in a commercial context. *Continental T.V., Inc. v. GTE Sylvania, Inc.; Broadcast Music, Inc. v. Columbia Broadcasting*—fully support this Court's determination that the Rule of Reason is the governing standard in this case.

Finally, the Supreme Court reiterated in *Broadcast Music, Inc. v. Columbia Braodcasting* that "[i]t is only after considerable experience with certain business relationships that courts classify them as *per se* violations." *Id.* at 1557. See *White Motor Co. v. United States*, 372 U.S. 253, 263,

*Despite this Court's decision, plaintiff stubbornly and incorrectly continues to contend that *Professional Engr's* was decided under a *per se* test.

(1963) ("We need to know more than we do about the actual impact of these arrangements on competition to decide whether they have a 'pernicious effect on competition and lack . . . any redeeming virtue' [citation omitted] and therefore should be classified as *per se* violations of the Sherman Act"). In fact, it was the sudden imposition of a *per se* rule by the *Schwinn* decision—only four (4) years after the Court in *White Motor Co.* refused to take that step—that so disturbed the Court in *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 97 S. Ct. at 2556, 2558. The Court concluded that *Schwinn* had precipitously endorsed a *per se* rule for vertical restrictions. Similarly here, there has been too little antitrust experience with the foundation concept for offering a lower cost alternative health insurance plan to blindly apply, as would plaintiff, a rigid *per se* analysis in the present case and this Court was correct in refusing to do so.*

B. THE COURT'S JUNE 5, 1979 MEMORANDUM AND ORDER IS INAPPROPRIATE FOR CERTIFICATION PURSUANT TO 28 U.S.C. § 1292(b).

Plaintiff has moved the Court pursuant to 28 U.S.C. § 1292(b) to certify its Memorandum and Order of June 5, 1979, arguing that the question of whether practices challenged in this case should be analyzied under the "Rule of Reason" is a "controlling question of law as to which there is a substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation." 28 U.S.C. § 1292(b). Plaintiff's motion is unfounded as it is clear that no "substantial ground for difference of opinion" exists. In *Berger v. United States*, 170 F. Supp. 795 (S.D.N.Y. 1959),

*In fact, it has only been within the last four (4) years—since the decision in *Goldfarb v. Virginia State Bar*—that the antitrust laws were held by the Supreme Court to be applicable at all to professions. Given this short time span, application of the *per se* rule to a professional group, as plaintiff contends, would be precipitous, ill-advised and inappropriate.

the court stated that whether there is substantial ground for difference of opinion depends on whether the appellant "has a good enough chance of success so that its appeal ought to be given special treatment." 170 F. Supp. at 796. The court in *Berger* refused to certify its denial of a motion to dismiss for lack of jurisdiction because it foresaw no probability that its decision would be reversed. *Seven-Up Co. v. O-So Grape Co.*, 179 F. Supp. 167, 172 (S.D. Ill. 1959) (court denying certification under 28 U.S.C. § 1292(b) stated: "A question of law 'as to which there is substantial ground for difference of opinion' as that phrase is used in the statute, must be construed as synonymous with a substantial likelihood that appellant's position would prevail on appeal.").

In the present case, there is no substantial likelihood that this Court's decision to review Maricopa Foundation's conduct under the Rule of Reason will be reversed. The Supreme Court has recently stated that the Rule of Reason is "the standard traditionally applied for the majority of anticompetitive practices challenged under § 1 of the [Sherman] Act." *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 97 S. Ct. at 2563. More specifically, the Supreme Court and the Ninth Circuit have both endorsed the Rule of Reason as the preferred method of analysis where the conduct allegedly violating the antitrust laws involves a profession. *national Soc'y of Professional Engr's v. United States; Boddicker v. Arizona State Dental Ass'n.* Under these circumstances, it can hardly be said that this Court has departed from established precedent or fashioned a new doctrine in a novel area. There is therefore no basis for concluding that the Court's Memorandum and Order of June 5, 1979 presents a question as to which there is "a substantial ground for difference of opinion."

Moreover, certification will not materially advance the ultimate termination of the litigation because under either the *per se* rule or Rule of Reason plaintiff cannot prevail on the facts. And it is the actual facts of the case that plaintiff continually ignores in repeatedly pressing for summary adjudication and now an interlocutory appeal.

Conclusion

For the foregoing reasons, plaintiff's motion for reconsideration or, alternatively, certification should be denied. Maricopa Foundation further submits that the Court should award Maricopa Foundation its reasonable attorney's fees for being forced to respond to these motions.

July 23, 1979

(Signatures omitted in printing.)

Filed - JUL 31, 1979
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

DEFENDANT MARICOPA FOUNDATION FOR MEDICAL CARE'S STATEMENT OF MATERIAL FACTS AS TO WHICH THERE IS A GENUINE DISPUTE PRECLUDING SUMMARY JUDGMENT IN FAVOR OF THE PLAINTIFF

Defendant Maricopa Foundation for Medical Care ("Maricopa Foundation") submits, pursuant to Local Rule 11(h), this statement of material facts which preclude summary judgment in favor of the plaintiff.

A. Defendant Maricopa Foundation disputes plaintiff's contention that the following paragraphs of "Statement of Undisputed Facts Supporting Plaintiff's Motion for Summary Judgment and Permanent Injunction" are not disputed:*

1. With respect to plaintiff's Statement 1, the membership of Maricopa Foundation includes medical doctors, osteopaths, podiatrists and oral surgeons. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 1 with respect to the Pima Foundation for Medical Care ("Pima Foundation"), the Pima County Medical Society ("Pima Society") and the Maricopa County Medical Society ("Maricopa Society"). [Maricopa Foundation's Response to Plaintiff's First Request for Admissions and Interrogatories "RFA" 310, 311]

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*The Court should note that many of plaintiff's alleged "Undisputed Facts" were previously identified by Maricopa Foundation as being disputed in Defendant Maricopa Foundation for Medical Care's Statement of Material Facts as to Which There Is a Genuine Issue Precluding Summary Judgment in Favor of the Plaintiff on the Issue of Liability dated December 11, 1978. See *e.g.*, para. A.1. *id.*

2. With respect to plaintiff's Statement 2, Maricopa Foundation admits that from time to time during 1975 it informed Maricopa Society of some of its activities, but has no information sufficient to admit or deny that Maricopa Society or Pima Society approved of Maricopa Foundation's activities or that Pima Society knew of Maricopa Foundation's activities. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 2 with respect to knowledge or approval of Pima Foundation's activities by Maricopa Society or Pima Society.

3. With respect to plaintiff's Statement 3, Maricopa Foundation was founded by its membership, *inter alia*, to promote the practice of medicine in Maricopa County on a fee for service basis. [RFA 91, affidavit of Anthony D. Mitten sworn to November 17, 1978, para. 2] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 3 with respect to Pima Foundation, Pima Society or Maricopa Society.

4. Denies plaintiff's Statement 4 with respect to Maricopa Foundation and states as of February 1977, Maricopa Foundation's membership consisted of approximately 1,052 persons. [RFA 268] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 4 with respect to Pima Foundation, Pima Society, and Maricopa Society.

5. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 5.

6. With respect to plaintiff's Statement 6,* members of the Board of Directors of Maricopa Society are entitled to become administrative members of Maricopa Foundation; to qualify as a participating member of Maricopa Foundation, a physician must be licensed to practice medicine or osteopathy in Arizona; to qualify as a cooperating member of Maricopa Foundation, a doctor must be licensed

*Apparently the numerical designation for this paragraph was inadvertently omitted in plaintiff's papers.

to practice podiatry or oral surgery in Arizona. [RFA 3, 310, 311]

7. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 7.

8. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 8.

9. With respect to plaintiff's Statement 9, pursuant to the By-Laws of Maricopa Foundation, every person, upon becoming a member of the Board of Directors of the Maricopa Society, is entitled to become and, without further action or proceeding becomes an administrative member of Maricopa Foundation. [RFA 3]

10. With respect to plaintiff's Statement 10, pursuant to the By-Laws of Maricopa Foundation, its administrative members have the authority to elect by majority vote members of the Board of Trustees of Maricopa Foundation and have exercised that authority.

11. With respect to plaintiff's Statement 11, the By-Laws of Maricopa Foundation provide that the Executive Committee of Maricopa Foundation shall be composed of three or more participating members of Maricopa Foundation and that nine of the twelve members of Maricopa Foundation's Board of Trustees shall be participating members of Maricopa Foundation. [Ch. V; § 2 and Ch. VI, § 4, By-Laws of Maricopa Foundation, MF-122]

12. With respect to plaintiff's Statement 12, included in the powers of Maricopa Foundation's Board of Trustees is the power to recommend for approval to its membership maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans. [Ch. V, § 2, By-laws of Maricopa Foundation, MF-122]

13. With respect to plaintiff's Statement 13, participating and cooperating members of Maricopa Foundation have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans. [RFA 34]

14. With respect to plaintiff's Statement 14 each participating member in Maricopa Foundation executes an application for membership wherein he agrees "to be bound during the period of the membership applied for with respect to maximum fees charged patients covered by Foundation sponsored plans by any fee determination by the Foundation consistent with the schedule adopted by the membership and agree also to be bound with respect to patients covered by Foundation sponsored plans during the period of membership applied for by any agreements, contracts, or statements of policy entered into or adopted by the Foundation concerning the rendering of medical care and the cost thereof" and wherein he further specifically states "I understand and agree that participating membership in the Foundation shall not affect the method of computation or amount of fees billed by me with respect to any medical care for any patient." [RFA 14; Affidavit of Anthony D. Mitten sworn to November 17, 1978, para. 3 and exhibit A thereto]

15. With respect to plaintiff's Statement 15, although the By-Laws of Maricopa Foundation provide for the existence of a standing committee entitled the "fee schedule committee" said committee never was a standing committee and only met infrequently on an ad hoc basis and has not existed since July 1977. [Ch. X, § 2, By-Laws of Maricopa Foundation, MF-122]

16. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 16.

17. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 17.

18. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 18.

19. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 19.

20. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 20.

21. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 21.

22. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 22.

23. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 23.

24. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 24.

25. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 25.

26. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 26.

27. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 27.

28. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 28.

29. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 29.

30. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 30.

31. With respect to plaintiff's Statement 31, as of February 1977, Maricopa Foundation's membership, including all classes of members, consisted of approximately 1,052 persons. Maricopa Foundation does not have information as to how many of them are medical doctors who reside in Maricopa County, Arizona. [RFA 268]

32. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 32.

33. With respect to plaintiff's Statement 33, Maricopa Foundation enters membership agreements with its participating and cooperating members annually. [RFA 13] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 33 with respect to Pima Foundation.

34. With respect to plaintiff's Statement 34, Maricopa Foundation repeats its response to plaintiff's Statement 14. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 34 with respect to Pima Foundation.

35. With respect to plaintiff's Statement 35, Maricopa Foundation repeats its responses to plaintiff's Statements 4 and 31.

36. With respect to plaintiff's Statement 36, Maricopa Foundation repeats its response to plaintiff's Statement 3.

37. With respect to plaintiff's Statement 37, both Maricopa Foundation and plaintiff have prepared relative value schedules based in part upon the 1964 edition of the Relative Value Schedule adopted by the California Medical Association, the Relative Value Guide adopted by the American Society of Anesthesiologists and the Relative Value Schedule of the American College of Radiology. [RFA 19, 21, 23; Supplemental Response of the State of Arizona to Maricopa Foundation's First Set of Interrogatories 22 through 25] Maricopa Foundation uses the relative value schedules prepared by it, together with conversion factors adopted by its membership, solely to determine the

maximum reimbursable levels of compensation payable by a third party payor to doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans. [RFA 29] Maricopa Foundation has not publicized and encouraged the use of relative value schedules and does not prepare or publish any schedule of fees to be charged by doctors. Maricopa Foundation does not affect in any way prices paid for goods and products sold by doctors to individuals insured under Maricopa Foundation-endorsed health insurance plans and has no price list or schedule for them. [Affidavit of Anthony D. Mitten sworn to December 11, 1978, paras. 2 and 8] Maricopa Foundation has sent to its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and has sent said lists to non-member doctors requesting membership information and applications. [RFA 57-58] Plaintiff has sent to doctors relative value schedules and conversion factors to be used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients for which plaintiff has assumed a payment obligation. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 37 with respect to Pima Foundation.

38. With respect to plaintiff's Statement 38, participating and cooperating members of the Maricopa Foundation have the right to vote on the adoption of maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans. These votes have been conducted by mail ballot. Maricopa Foundation has not polled its members as to relative value schedules and unit conversion factors they prefer or relative value schedules and unit conversion factors they consider appropriate to Maricopa Foundation. [RFA 34, 35, 36, 156, 164 & 235] Maricopa Foundation has

not proposed any schedule of fees to be charged by its members. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 38 with respect to Pima Foundation.

39. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 39.

40. With respect to plaintiff's Statement 40, Maricopa Foundation repeats its response to plaintiff's Statement 38 and further states that mail ballots with respect to the maximum reimbursable levels referred to in Maricopa Foundation's response to plaintiff's Statement 38 were taken on or about July 1974, October 1975 and October 1977 and did not result in adoption of any schedule of fees to be charged.

41. With respect to plaintiff's Statement 41, Maricopa Foundation's By-Laws uses the language "uniform average or median fee schedules for medical services by the Foundation" to refer to the maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans. [Ch. II, § 5, By-Laws of Maricopa Foundation, MF-122] Maricopa Foundation does not use the term "uniform fee schedule" to refer to any schedule of fees to be charged by doctors. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 41 with respect to Pima Foundation.

42. With respect to plaintiff's Statement 42, Maricopa Foundation has stated from time to time in correspondence that maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans should approximate the median of physician charges for services

rendered. But see Maricopa Foundation's response to plaintiff's Statement 71 with respect to the relation between actual maximum reimbursable levels of compensation to doctors and usual and customary fees charged by doctors.

43. With respect to plaintiff's Statement 43, Maricopa Foundation has entered into agreements with insurers and other third party payors pursuant to which those insurers and third party payors agree to write health insurance for certain groups which is not inconsistent with Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs." [RFA 11] Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs" includes a maximum reimbursable payment schedule with respect to payments by the insurer or third party payor to doctors for services provided to patients insured under Maricopa Foundation-endorsed group insurance plans. [RFA 10] Insurers and other third party payors agree to reimburse doctors for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans, less any agreed deductible payable by the insured, in accordance with their usual and customary fees charged for such services but not to exceed the maximum reimbursable level of compensation set forth in Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs." [RFA 12] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 43 with respect to Pima Foundation.

44. With respect to plaintiff's Statement 44, Maricopa Foundation repeats its response to plaintiff's Statement 43.

45. With respect to plaintiff's Statement 45, Maricopa Foundation repeats its response to plaintiff's Statement 43.

46. With respect to plaintiff's Statement 46, Maricopa Foundations repeats its response to plaintiff's Statement 43.

47. With respect to plaintiff's Statement 47, Maricopa Foundation's "Minimum Standards for Foundation-Endorsed Group Insurance Programs" provides that "professional payments" by an insurer or other third party payor for services rendered to patients insured under Maricopa Foundation-endorsed health insurance plans are restricted to duly licensed physicians and surgeons of medicine and osteopathy, doctors of dentistry and doctors of podiatry. [MF-64] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 47 with respect to Pima Foundation.

48. With respect to plaintiff's Statement 48, Maricopa Foundation states that in each instance involving Maricopa Foundation the insurer or other third party payor retains the right to make the final determination of the maximum reimbursement to be made to any doctor for any service. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 48 with respect to Pima Foundation.

49. With respect to plaintiff's Statement 49, to determine the maximum reimbursable payment to a doctor for services rendered to a patient insured under a Maricopa Foundation-endorsed health insurance plan, one must refer both to the applicable relative value schedule and the applicable conversion factor. Maricopa Foundation's peer review must also determine that the services are medically necessary or appropriate before any payment is made. [RFA 17] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 49 with respect to Pima Foundation.

50. Maricopa Foundation denies plaintiff's Statement 50 and repeats its response to plaintiff's Statements 37 and 38. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 50 with respect to Pima Foundation.

51. With respect to plaintiff's Statement 51, plaintiff purports to have appended true and exact copies of consent decrees entered with respect to *In re California Medical Association*, FTC File No. 781005 (FTC, filed November 14, 1977) and *In re The American College of Radiology*, FTC File No. 7610059 (FTC, filed September 13, 1977) but they are irrelevant and immaterial to this action.

52. With respect to plaintiff's Statement 52, one possible definition for the term "relative value schedule" may be "a compilation of medical procedures to which are assigned unit values based upon the normal degree of complexity for each procedure; relative value schedules may also include a uniform nomenclature describing medical procedures and a standardized coding system for use by actuaries and others."

53. With respect to plaintiff's Statement 53, Maricopa Foundation repeats its response to plaintiff's Statement 37.

54. With respect to plaintiff's Statement 54, Maricopa Foundation repeats its response to plaintiff's Statement 37.

55. With respect to plaintiff's Statement 55, Maricopa Foundation repeats its response to plaintiff's Statement 37.

56. With respect to plaintiff's Statement 56, Maricopa Foundation denies that it published a conversion manual such as Exhibit H to plaintiff's Supplemental Rule 11(h) Statement with respect to plaintiff's Motion for Partial Summary Judgment.

57. Maricopa Foundation denies plaintiff's Statement 57 and repeats its responses to plaintiff's Statements 37, 38, 40 and 43.

58. Maricopa Foundation denies plaintiff's Statement 58, repeats its responses to plaintiff's Statements 37, 38, 40 and 43 and further states that Maricopa Foundation has on a non-periodic basis requested various professional organizations whose members are doctors to advise Maricopa Foundation in connection with Maricopa Foundation's in-

dependent determination of the maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members for adoption. Maricopa Foundation has not polled these various professional organizations as to relative value schedules and unit conversion factors their members use or the fees their members usually charge. [RFA 44-53] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 58 with respect to Pima Foundation.

59. Maricopa Foundation denies plaintiff's Statement 59.

60. With respect to plaintiff's Statement 60, Maricopa Foundation repeats its response to plaintiff's Statement 58.

61. With respect to plaintiff's Statement 61, Maricopa Foundation repeats its response to plaintiff's Statement 58.

62. Maricopa Foundation denies plaintiff's Statement 62.

63. With respect to plaintiff's Statement 63, Maricopa Foundation has on two occasions surveyed its members as to their usual and customary fees for medical services and as to what conversion factors and relative value schedules they used for the purpose of calculating their usual and customary fees for medical services. The results of those surveys were not published and were used solely to assist Maricopa Foundation in making an independent determination of the maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans to be proposed to Maricopa Foundation's participating and cooperating members. [RFA 37-43] Maricopa Foundation further responds by repeating its response to plaintiff's Statement 38.

64. With respect to plaintiff's Statement 64, Maricopa Foundation repeats its response to plaintiff's Statement 58.

65. With respect to plaintiff's Statement 65, Maricopa Foundation has sent to its members lists of conversion factors used by it to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and has sent said lists to non-member doctors requesting membership information and applications. Maricopa Foundation does not publish or distribute relative value schedules or conversion factors used by it to non-members except to insurers who may be interested in underwriting Maricopa Foundation-endorsed health insurance plans and persons eligible for membership in Maricopa Foundation who have expressed an interest in joining Maricopa Foundation. [RFA 57-58] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 65 with respect to Pima Foundation.

66. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 66.

67. With respect to plaintiff's Statement 67, Maricopa Foundation repeats its responses to plaintiff's Statement 37 and 65.

68. With respect to plaintiff's Statement 68, Maricopa Foundation repeats its response to plaintiff's Statement 65.

69. With respect to plaintiff's Statement 69, Maricopa Foundation repeats its responses to plaintiff's Statement 37 and 65.

70. With respect to plaintiff's Statement 70, Maricopa Foundation repeats its responses to plaintiff's Statements 14 and 34. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 70 with respect to Pima Foundation.

71. With respect to plaintiff's Statement 71, at no time has Maricopa Foundation set a maximum reimbursable level of compensation for medical services provided to patients insured under Maricopa Foundation-endorsed health insurance plans in excess of what Maricopa Foundation's

Board of Trustees believed to be the prevailing average or median usual and customary fee charged by doctors in Maricopa County for their services. [Affidavit of Anthony D. Mitten sworn to December 11, 1978, para. 6] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 71 with respect to Pima Foundation.

72. Maricopa Foundation denies plaintiff's Statement 72.

73. With respect to plaintiff's Statement 73, Maricopa Foundation has sent to Pima Foundation conversion factors used by Maricopa Foundation to determine maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans and states that it has no sufficient information to admit or deny the remainder of plaintiff's Statement 73 insofar as it pertains to Pima Foundation.

74. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 74.

75. With respect to plaintiff's Statement 75, it is the practice of Maricopa Foundation to advise insurers underwriting health insurance plans endorsed by Maricopa Foundation in advance of expected changes to maximum reimbursable levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans. [RFA 61] Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 75 with respect to Pima Foundation.

76. With respect to plaintiff's Statement 76, Maricopa Foundation maximum reimbursement levels of compensation to doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans effect payment to doctors and health insurance

premiums charged for Maricopa Foundation-endorsed health insurance plans. Maricopa Foundation has no information sufficient to admit or deny plaintiff's Statement 76 with respect to Pima Foundation.

77. With respect to plaintiff's Statement 77, on or about November 30, 1973, Maricopa Foundation asked an insurance consultant to provide actuarial assistance in estimating increases in premiums on Maricopa Foundation-endorsed health insurance plans likely to occur as a result of increases in the maximum reimbursable levels of compensation for doctors providing medical services to patients insured under Maricopa Foundation-endorsed health insurance plans proposed to become effective on or after January 1, 1974. [RFA 143]

78. With respect to plaintiff's Statement 78, on or about April 19, 1976, Maricopa Foundation's Board of Trustees approved an increase in Maricopa Foundation's deductible, which increase had been recommended by Maricopa Foundation's Insurance Advisory Committee, to provide greater flexibility in Maricopa Foundation's Minimum Standards in order for Maricopa Foundation-endorsed plans to continue to be saleable items. [Minutes of Maricopa Foundation Insurance Advisory Committee Meeting held March 18, 1976; Minutes of Maricopa Foundation Board of Trustees dated April 19, 1976]

79. With respect to plaintiff's Statement 79, plaintiff's Response to Maricopa Foundation's First Set of Interrogatories No. 9(A) reflects, *inter alia*, that in 1966, the State of Arizona paid approximately $75,867,000 to doctors in Arizona and Maricopa Foundation does not have sufficient information to admit or deny that statement.

80. With respect to plaintiff's Statement 80, plaintiff's Response to Maricopa Foundation's First Set of Interroga-

tories No. 9 reflect, *inter alia*, that in 1975, the State of Arizona paid approximately $218,279,000 to Arizona doctors and Maricopa Foundation does not have sufficient information to admit or deny that statement.

81. With respect to plaintiff's Statement 81, plaintiff's Response to Maricopa Foundation's First Set of Interrogatories No. 3(a) reflects, *inter alia*, that the State of Arizona, Division of Finance, pays approximately $7.6 million per year for health insurance premiums and Maricopa Foundation does not have sufficient information to admit or deny that statement.

82. With respect to plaintiff's Statement 82, plaintiff's Supplementary Response to Interrogatory 3(a) of defendant Maricopa Foundation for Medical Care's First Set of Interrogatories reflects, *inter alia*, the insurance premiums paid by the State of Arizona as set forth in plaintiff's Statement 82 and Maricopa Foundation does not have sufficient information to admit or deny that statement.

83. With respect to plaintiff's Statement 83, Maricopa Foundation administers the State of Arizona's Comprehensive Medical/Dental Program for Foster Children and makes payments to doctors providing services to foster children pursuant to the maximum allowable fee schedule of the Department of Economic Security, which schedule provides for payments in excess of those which would be made under Maricopa Foundation's maximum reimbursable levels of compensation to doctors providing services to patients insured under Maricopa Foundation-endorsed health insurance plans.

B. Maricopa Foundation incorporates herein by reference the facts set forth in the affidavits of Anthony D. Mitten, sworn to December 17, 1978 and December 11, 1978 which set forth material facts precluding summary judgment in favor of plaintiff.

July 31, 1979.

(Signature omitted in printing.)

Filed - AUG 22, 1979
Richard H. Deane, Clerk
U. S. Court of Appeals

(Caption omitted in printing.)

EMERGENCY MOTION OF APPELLEES MARICOPA FOUNDATION FOR MEDICAL CARE AND PIMA FOUNDATION FOR MEDICAL CARE TO VACATE INJUNCTION AND DISMISS APPEAL AND FOR EXPEDITED HEARING AND ACCELERATED BRIEFING

Appellees Maricopa Foundation for Medical Care ("Maricopa Foundation") and Pima Foundation for Medical Care ("Pima Foundation") move, pursuant to Rule 8(a) of the Federal Rules of Appellate Procedure and Rule 6(g) of the Rules of the United States Court of Appeals for the Ninth Circuit, for an order vacating the injunction entered by this Court August 17, 1979 herein and dismissing this appeal for lack of jurisdiction.

Alternatively, Maricopa Foundation moves, pursuant to Rule 8(b) of the Federal Rules of Appellate Procedure, for entry of an order conditioning continuation of the injunction entered by this Court August 17, 1979 herein upon the giving of security by appellant State of Arizona in the amount of not less than $850,000 and for an order setting this appeal for accelerated hearing on an emergency basis during September 1979 with acceleration of the briefing schedule for the appeal as is appropriate.

Additionally, Maricopa Foundation and Pima Foundation move, pursuant to Rule 27 of the Federal Rules of Appellate Procedure, for expedited hearing and accelerated briefing of this Motion and for its determination by Friday, August 31, 1979.

This motion is based upon the attached memorandum of points and authorities, the attached affidavits of Anthony D. Mitten sworn to August 22, 1979, Lawrence Shapiro sworn to August 22, 1979, and Philip P. Berelson sworn to August 22, 1979. Pima Foundation will supplement this motion with an affidavit of one of its officers. Some of the grounds advanced in support of this motion were not submitted to the District Court for the reason that the questions of whether this Court has erred in entering an injunction pending appeal and in taking jurisdiction of this matter where never before the District Court and it would not be appropriate for the District Court to consider those questions on remand.

Opposing counsel are Robert K. Corbin, Attorney General of the State of Arizona, Kenneth R. Reed, Chief Counsel, Antitrust Division, and Patricia A. Metzger, Assistant Attorney General, Antitrust Division, 303 West Wing, State Capitol Building, Phoenix, Arizona 85007, tel. 602/255-4751.

Moving counsel for Maricopa Foundation are Philip P. Berelson, Jennifer B. Beaver, Robert C. Houser, Brown & Bain, P.A., 222 North Central Avenue, Phoenix, Arizona 85004, tel. 602/257/8777, and for Pima Foundation, Robert O. Lesher, Lesher, Kimble & Rucker, P.C., 3773 East Broadway, Tucson, Arizona 85716, tel. 602/795-1470.

Counsel for the other appellee, who has authorized Maricopa Foundation's counsel to represent that its client is in favor of the granting of this motion, is Daniel J. McAuliffe, Snell & Wilmer, 3100 Valley Bank Center, Phoenix, Arizona 85073, tel. 602/257-7272, attorneys for appellee Maricopa County Medical Society.

August 22, 1979.

(Signatures omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF
LAWRENCE SHAPIRO

STATE OF ARIZONA }
} ss.
County of Maricopa }

LAWRENCE SHAPIRO, being first duly sworn, upon oath deposes and says:

1. I am Vice President of Maricopa Foundation for Medical Care ("Maricopa Foundation") and from January 1, 1976 to December 31, 1977 I was President of Maricopa Foundation. I have been a member of the Board of Trustees of Maricopa Foundation from 1971 through the present time. I make this affidavit in support of Maricopa Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's ("Arizona") appeal from the Order of the District Court vacating temporary restraining order.

2. Based on my experience as a medical doctor practicing in Maricopa County and as a member of the Board of Trustees and officer of Maricopa Foundation, unless this Court vacates the injunction entered by it on August 17, 1979 in this matter, appellee Maricopa Foundation will cease to function as a viable competitive alternative for provision of health care services at the end of 1979. My belief is based upon the facts set forth below.

3. It is my belief that the marketability of Maricopa Foundation-endorsed health insurance depends in large part on (a) consumers' desire to purchase insurance such as Foundation-endorsed insurance which will pay 100% of physicians' charges for any given service; (b) consumers' desire to have a wide choice of physicians who have agreed to accept as payment in full the payment from the insurer; (c) competitive price of Foundation-endorsed insurance relative to other health insurance plans.

4. It is my belief that unless the Maricopa Foundation is able to increase the maximum amounts paid for various medical services, physicians who presently belong to Maricopa Foundation will find it economically impossible to continue their membership because the difference between maximum amounts paid by Maricopa Foundation and amounts charged by physicians in Maricopa County has grown steadily since the last Maricopa Foundation maximum reimbursement rate increase in December 1977.

5. Therefore, many Maricopa Foundation member physicians will not renew their membership for 1980 and as a result the advantage to the consumer of Maricopa Foundation-endorsed insurance coverage, *i.e.*, their desire to have a wide choice of physicians who accept Maricopa Foundation payment as payment in full, will disappear.

6. I believe that insurance groups which have in the past utilized Maricopa Foundation-endorsed insurance as one of the health care alternatives available to their employees are unlikely to renew offering Maricopa Foundation-endorsed health care insurance as an alternative in 1980 if Maricopa Foundation is not permitted to increase the maximum levels of reimbursement which it pays for medical services to patients insured under Maricopa Foundation endorsed health insurance. Patients who are treated by physicians who are not Maricopa Foundation members are obligated to pay the difference between Maricopa Foundation's maximum reimbursement rate and the billing they receive from their physician. At present, the difference between the Maricopa Foundation maximum reimbursement rate and the usual and customary fees charged by the majority of physicians in the community is so great that any prospect of a substantial decrease in the number of physicians who are members of the Maricopa Foundation obligated to accept its maximum reimbursement rates as payment in full

will make non-Maricopa Foundation-endorsed health insurance more attractive in terms of total cost to the insurer and to the patient than Maricopa Foundation-endorsed insurance.

7. For the reasons set forth above, I believe that if Maricopa Foundation is required not to change any relative value or conversion factor while Arizona's appeal is pending, that the practical effect will be the same as if a permanent injunction had been entered against Maricopa Foundation since Maricopa Foundation will not be a viable health insurance alternative by the time that the pending appeal is finally determined.

(Signature and notary clause omitted in printing)

(Caption omitted in printing.)

AFFIDAVIT OF ANTHONY D. MITTEN

STATE OF ARIZONA }
} ss.
County of Maricopa }

ANTHONY D. MITTEN, being duly sworn, upon oath deposes and says:

1. I am Executive Director of defendant-appellee Maricopa Foundation for Medical Care ("Maricopa Foundation"). I make this affidavit in support of Maricopa Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's appeal from the order of the District Court vacating temporary restraining order.

2. Maricopa Foundation presently limits compensation to physicians who provide services to patients insured under Maricopa Foundation endorsed health insurance programs in accordance with a maximum level of reimbursement that has been in effect since December 1, 1977.

3. Increasing numbers of Maricopa Foundation member physicians have requested that they be allowed to terminate their memberships because Maricopa Foundation's current maximum levels of reimbursement in many cases do not adequately compensate the physicians for the services they provide. I believe that unless Maricopa Foundation is permitted to announce before the end of 1979 that it will increase maximum levels of reimbursement to Maricopa Foundation members for treating patients insured under Maricopa Foundation endorsed health insurance plans, that between one-quarter and one-half of the physician membership will refuse to renew their membership at the end of 1979. That loss of physician membership by Maricopa Foundation will result in Mari-

copa Foundation endorsed health insurance plans no longer being a viable alternative health care plan for the large employer groups which are currently using Maricopa Foundation endorsed health insurance plans.

4. Under contracts currently in force, Maricopa Foundation will be paid in excess of $700,000 in fees for administering health insurance plans during 1979. Based upon my experience as Executive Director of Maricopa Foundation I believe that if the injunction entered by the Ninth Circuit Court of Appeals remains in force, Maricopa Foundation's income from administering insurance plans will be reduced by between $400,000 and $450,000 in 1980. If that injunction remains in force and Arizona's appeal is not decided during 1980, in my opinion Maricopa Foundation's income from administering health insurance plans will be reduced by in excess of $450,000 in 1981.

5. Under Maricopa Foundation's regular procedure it is unable to make any modification to relative values or conversion factors or maximum reimbursement levels in less than sixty days. In addition, Maricopa Foundation has normally given insurers no less than sixty days advance notice of any significant change in maximum reimbursement levels in order for the insurer to evaluate the impact of the change and determine whether or not to continue to offer a Maricopa Foundation endorsed health insurance plan. For that reason, if the injunction entered by the Ninth Circuit Court of Appeals is not vacated by the beginning of September 1979, Maricopa Foundation will be damaged and, as the month of September goes by, the damage will become increasingly more severe. Motorola, Incorporated ("Motorola") insures the largest Maricopa Foundation endorsed health insurance group. Maricopa Foundation must inform Motorola of any anticipated change in maximum reimbursement levels for Maricopa Foundation endorsed health insurance in September or its contractual relationship with Motorola will be irreparably damaged. It is extremely unlikely that Motorola will continue any contrac-

tual relationship with Maricopa Foundation if Maricopa Foundation is unable to discuss with Motorola changes to relative values and conversion factors which will be used in connection with Motorola's insureds during 1980.

6. For the foregoing reasons I respectfully but earnestly request that Maricopa Foundation's motion be granted as soon as possible in order to minimize the harm which Maricopa Foundation will inevitably suffer as a result of the injuction order which was filed August 17, 1979.

(Signature and notary clause omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF THOMAS P. FINLEY

STATE OF ARIZONA }
} ss.
County of Maricopa }

THOMAS P. FINLEY, being first duly sworn upon oath, deposes and says:

1. I am Executive Director fo Defendant-Appellee Pima Foundation for Medical Care (PFMC). I make this affidavit in support of Pima Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's appeal from the Order of the District Court vacating Temporary Restraining Order.

2. Pima Foundation presently limits compensation to physicians who provide services to patients insured under Pima Foundation-endorsed health insurance programs in accordance with a maximum level of reimbursement that has been in effect since December 1, 1977.

3. Increasing numbers of Pima Foundation member physicians have requested that they be allowed to terminate their memberships because Pima Foundation's current maximum levels of reimbursement in many cases do not adequately compensate the physicians for the services they provide. I believe that unless Pima Foundation is permitted to announce before the end of 1979 that it will increase maximum levels of reimbursement to Pima Foundation members for treating patients insured under Pima Foundation endorsed health insurance plans that between one-quarter andd one-third of the physician membership will refuse to renew their membership at the end of 1979. That loss of physician membership by Pima Foundation will re-

sult in Pima Foundation-endorsed health insurance plans no longer being a viable alternative health care plan for the large employer groups which are currently using Pima Foundation endorsed health insurance plans.

4. Under contracts currently in force, Pima Foundation will be paid in excess of $77,000 in fees for administering health insurance plans during 1979. Based upon my experience as Executive Director of Pima Foundation, I believe that if the injunction entered by the Ninth Circuit Court of Appeals remains in force, Pima Foundation's income from administering insurance plans will be reduced by between $25,000 and $40,000 in 1980. If that injunction remains in force and Arizona's appeal is not decided during 1980, in my opinion, Pima Foundation's income from administering health insurance plans will be reduced by in excess of $45,000 in 1981.

5. Under Pima Foundation's regular procedure, it is unable to make any modification to relative values or conversion factors or maximum reimbursement levels in less than 60 days. In addition, Pima Foundation has normally given insurers no less than 60 days advance notice of any significant change in maximum reimbursement levels in order for the insurer to evaluate the impact of the change and determine whether or not to continue to offer a Pima Foundation-endorsed health insurance plan. For that reason, if the injunction entered by the Ninth Circuit Court of Appeals is not vacated by the beginning of September, 1979, Pima Foundation will be damaged, and, as the month of September goes by, the damage will become increasingly more severe. Tucson Public School District No. 1 insures the largest Pima Foundation-endorsed health insurance group. Pima Foundation must inform Tucson Public School District No. 1 of any anticipated change in maximum reimbursement levels for Pima Foundation-endorsed health insurance in September, or its contractual relationship with Tucson Public School District will be irreparably damaged. It is extremely unlikely that Tucson Public School District

will continue any contractual relationship with Pima Foundation if Pima Foundation is unable to discuss with Tucson Public School District changes to relative values and conversion factors which will be used in conjunction with Tucson Public School District's insureds during 1980. This same situation applies to the Sunnyside School District, which is Pima Foundation's next largest account.

6. For the foregoing reasons, I respectfully and urgently request that Pima Foundation's Motion be granted as soon as possible to order to minimize the harm which Pima Foundation will inevitably suffer as a result of the injunction order which was filed August 17, 1979.

(Signature and notary clause omitted in printing.)

(Caption omitted in printing.)

AFFIDAVIT OF ARTHUR DUDLEY, JR., M.D.

STATE OF ARIZONA }
} ss.
County of Pima }

ARTHUR DUDLEY, being first duly sworn, upon oath deposes and says:

1. I am President of the Pima Foundation for Medical Care. As President, I serve as the governing member of the Board of Trustees of the Pima Foundation. I make this affidavit in support of Pima Foundation's emergency motion to vacate the injunction entered by the Ninth Circuit Court of Appeals pending determination of the State of Arizona's ("Arizona") appeal from the Order of the District Court vacating temporary restraining order.

2. Based on my experience as a medical doctor practicing in Pima County and as a member of the Board of Trustees and officer of Pima Foundation, unless this Court vacates the injunction entered by it on August 17, 1979, in this matter, appellee Pima Foundation will cease to function as a viable competitive alternative for provision of health care services at the end of 1979. My belief is based upon the facts set forth below.

3. It is my belief that the marketability of Pima Foundation endorsed health insurance depends in large part on (a) consumers' desire to purchase insurance such as Foundation-endorsed insurance which will pay 100% of physicians' charges for any given service; (b) consumers' desire to have a wide choice of physicians who have agreed to accept as payment in full the payment from the insurer; and (c) competitive price of Foundation-endorsed insurance relative to other health insurance plans.

4. It is my belief that unless the Pima Foundation is able to increase the maximum amounts paid for various medical services, physicians who presently belong to Pima Foundation will find it economically impossible to continue their

membership because the difference between maximum amounts paid by Pima Foundation and amounts charged by physicians in Pima County has grown steadily since the last Pima Foundation maximum reimbursement rate increase in December, 1977.

5. Therefore, many Pima Foundation member physicians will not renew their membership for 1980, and as a result, the advantage to the consumer of Pima Foundation-endorsed insurance coverage, i.e., their desire to have a wide choice of physicians who accept Pima Foundation payment as payment in full will disappear. In support of this statement, twenty anesthesiologists have already submitted their resignation to the Pima Foundation for Medical Care. In addition, forty-one members have submitted notice of resignation, primarily in the fields of obstetrics and gynecology and radiology. The principal underwriter of Pima Foundation contracts, Connecticut General Life Insurance Company is presently reimbursing for anesthesia services utilizing a conversion factor of $19 for their indemnity contracts. The Pima Foundation rate of reimbursement for the same service is based upon a conversion factor of $13.

6. The resignations of the anesthesiologists will be particularly detrimental to the Pima Foundation's efforts to market its product.

7. I believe that insurance groups which have in the past utilized Pima Foundation-endorsed insurance as one of the health care alternatives available to their employees are unlikely to renew offering Pima Foundation-endorsed health care insurance as an alternative in 1980 if Pima Foundation is not permitted to increase the maximum levels of reimbursement which it pays for medical services to patients insured under Pima Foundation-endorsed health insurance. Patients who are treated by physicians who are not Pima Foundation members are obligated to pay the difference between Pima Foundation's maximum reimbursement rate and the billing they receive from their physician.

At present, the difference between the Pima Foundation maximum reimbursement rate and the usual and customary fees charged by the majority of physicians in the community is so great that any prospect of a substantial decrease in the number of physicians who are members of the Pima Foundation obligated to accept its maximum reimbursement rates as payment in full will make non-Pima Foundation-endorsed health insurance more attractive in terms of total cost to the insurer and to the patient than Pima Foundation-endorsed insurance.

For the reasons set forth above, I believe that if Pima Foundation is required not to change any relative value or conversion factor while Arizona's appeal is pending that the practical effect will be the same as if a permanent injunction had been entered against Pima Foundation since Pima Foundation will not be a viable health insurance alternative by the time the pending appeal is finally determined.

(Signature and notary clause omitted in printing.)

Filed - MAY 30 1980
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

ORDER

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,*[1] District Judge

Plaintiff-Appellant's Petition for Rehearing and Suggestion of Appropriateness of Rehearing In Banc is ordered filed.

Filed - JUN 18 1980
W. J. Furstenau, Clerk
U. S. District Court
For The District of Arizona

(Caption omitted in printing.)

ORDER

Before: SNEED and KENNEDY, Circuit Judges, and LARSON,*[2] District Judge

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is denied and the suggestion for a rehearing en banc is rejected.

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*[1]Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.

*[2]Honorable Earl R. Larson, Senior United States District Judge for the District of Minnesota, sitting by designation.